The Lived Experience of Nursing Students with Formative Assessment Formally Embedded in Clinical Courses: A Transcendental Phenomenological Study

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Abstract

The potential of formative assessment (FA) for informing learning in classroom-based nursing courses is clearly established in the literature; however, research on FA in clinical courses remains scarce. This inquiry explored the lived experience of nursing students using transcendental phenomenology and described the phenomenon of being assessed in clinical courses. The research question guiding the study was: How is the phenomenon of assessment experienced by nursing students when FA is formally embedded in clinical courses? Inherent in this question were the following issues: (a) the meaning of clinical experiences for nursing students, (b) the meaning of being assessed through FA, and (c) what it is like to be assessed when FA is formally embedded within clinical experiences. The noematic themes that illuminated the *whatness* of the participants' experience were (a) enabled cognitive activity, (b) useful feedback, (c) freedom to be, (d) enhanced focus, (e) stress moderator, and (f) respectful mentorship. The noetic themes associated with *how* the phenomenon was experienced were related to bodyhood, temporality, spatiality, and relationship to others. The results suggest a fundamental paradigm shift from traditional nursing education to a more pervasive integration of FA in clinical courses so that students have time to learn before being graded on their practice. Furthermore, this inquiry and the literature consulted provide evidence that using cognitive science theory to inform and reform clinical nursing education is a timely option to address the repeated calls from nursing leaders to modernize nursing education. This inquiry contributes to reduce our reliance on assumptions derived from research on FA in nursing classrooms and provides evidence based on the reality of using formative assessment in clinical courses. Recommendations for future research are presented.

Dedication

This dissertation is dedicated to my late husband Claude. You were my biggest cheerleader, and although I know that you are still with me in spirit, I painfully missed your presence and unwavering support during the last year of writing this dissertation. Rest in Peace my love.

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CHAPTER ONE: INTRODUCTION TO THE PROBLEM

This chapter presents a comprehensive discussion of the issues guiding the decision to explore the phenomenon of assessment in clinical nursing education. My interest in this phenomenon is conveyed, a definition of relevant terms is provided, and the significance of the study is established.

At the dawn of the 21st century and projected beyond, nurses are expected to have adaptable knowledge and abilities that are readily transferable to the dynamic situations they encounter (Benner, Sutphen, Leonard, & Day, 2010; Catalano, 2012; McIntyre & McDonald, 2014; Ross-Kerr & Wood, 2011; Villeneuve & MacDonald, 2006). Del Prato (2010) reiterated concerns expressed by Benner et al. (2010) over the mounting amount of information emerging from specialized fields such as biotechnology and health research and its impact on the growing complexity of the environments where nurses are expected to practice. Likewise, many nursing leaders claimed that this consistent emergence of new information has challenged the field of nursing education to deliver curricula that ensure a supply of new nurses who enter the profession with specialized knowledge and abilities needed to thrive in the future (Anema & McCoy, 2010; Benner et al., 2010; Catalano, 2012; Ellis & Hartley, 2008; Haynes, Butcher & Boese, 2004; McIntyre & McDonald, 2014; Oermann & Gaberson, 2014; Villeneuve & MacDonald, 2006). Anema and McCoy (2010) suggested that in order to address the challenges generated by advances in technology and in order to graduate nurses who are well prepared to meet the dynamic nature of the workplace environments, "a culture of continuous improvement, based on innovations in technologies, teaching/learning strategies, and the recognition of learners as active participants is needed" (p. 13). The

research presented here focuses on the lived experience of nursing students with assessment and addresses repeated calls by nursing leaders to modernize the teaching–learning process in nursing education. Although the demand for inquiry into the traditional model of nursing education permeating the nursing literature relates to both classroom and clinical teaching practices (Anema & McCoy, 2010; Benner et al., 2010; Cannon & Boswell, 2012; Del Prato, 2010; Oermann & Gaberson, 2014; Villeneuve & MacDonald, 2006), this research focuses exclusively on clinical education.

The traditional model of nursing education stems from the historical beginnings of the profession where nursing was considered a "caring service" (Potter et al., 2014, p. 30). Florence Nightingale, the founder of modern nursing established a school where nurses were trained to care for the sick and to teach other nurses. At the time, an apprenticeship model where nursing students provided patient care in exchange for nursing education was used. With time, as nurses lobbied for improved educational standards, nursing programs were created and the education of students took priority over service to hospitals (Potter et al., 2014).

Clinical settings have been the mainstay of nursing education since its inception (Cannon & Boswell, 2012; Duteau, 2012; Oermann & Gaberson, 2014), and the fundamental connection between what is taught in nursing programs and the impact of clinical experiences in the development of nursing knowledge is widely addressed in the nursing literature. Although a broad variety of subject matter is an important aspect of nursing curricula, clinical experiences in different practice settings are pivotal to the construction of nursing knowledge and to the socialization of nursing students into their chosen profession (Benner, 1984; Budgen & Gamroth, 2008; Carper, 1978; Field, 2004;

Lynaugh, 2007; MacFarlane et al., 2007; McCutchan, 2010; Moyer & Wittmann-Price, 2008; Oermann & Gaberson, 2014; Reilly & Oermann, 1999; Reynolds, 2005). As suggested by Gaberson, Oermann, and Shellenbarger (2015), "because nursing is a professional practice discipline, the clinical practice of nurses and nursing students is more important than what they can demonstrate in a classroom" (p. 16). Supervised clinical experiences provide opportunities for nursing students to apply didactic content addressed in classrooms, in psychomotor skills laboratories, and embedded within the realities of nursing practice. Furthermore, clinical experiences provide real-life settings where the process of socialization and professional identify development occur (Carper, 1978; Field, 2004; Gaberson et al., 2015; Lynaugh, 2007; McCutchan, 2010; Reilly & Oermann, 1999; Reynolds, 2005).

Until recently, Canadian baccalaureate nursing programs required students to successfully complete one or more clinical practice courses in each of the four years of their curriculum (Ralph, Walker, & Wimmer, 2009). These courses consist mainly of supervised practical experiences where students provide nursing care to clients in different clinical settings but may involve learning various psychomotor skills in laboratory environments. With the emergence of technology such as high fidelity human patient simulators, the number and the unique nature of clinical courses within nursing programs has changed (Gaberson et al., 2015; Oermann & Gaberson, 2014). In the context of this inquiry, clinical settings refer to acute and chronic care areas within hospitals. Besides required theory courses, the participants in this study were enrolled in a program consisting of one clinical course during the first year and three clinical courses in each of the remaining three years of their nursing program.

A major challenge of nursing education is to foster student learning while maintaining the safety of all patients, including the acutely ill and vulnerable populations. Because students are expected to learn from their practice of caring for live human beings, clinical competence is a major issue and clinical assessment becomes essential in the measurement of their ability to provide safe care. For that reason, clinical performance appraisal (CPA) or the assessment of students' performance in clinical settings remains a fundamental component of nursing curricula (Bradshaw & Lowenstein, 2011; Cannon & Boswell, 2012; Carper, 1978; Field, 2004; Gaberson et al., 2015; Lynaugh, 2007; MacFarlane et al., 2007; McCutchan, 2010; Moyer & Wittmann-Price, 2008; O'Connor, 2001; Oermann & Gaberson, 2014; Reilly & Oermann, 1999; Reynolds, 2005). The nursing literature attributes many purposes to the process of CPA, such as (a) fostering learning, (b) helping to identify students' knowledge, (c) contributing to determine competence and ability to provide safe care, (d) measuring the level of achievement, and (e) determining whether the outcomes or standards of the curriculum have been met or whether the student has to repeat the course (Benner et al., 2010; DeYoung, 2009; Gaberson et al., 2015; McCutchan, 2010; Moyer & Wittmann-Price, 2008; Oermann & Gaberson, 2014; Reilly & Oermann, 1999; Reynolds, 2005). Consequently, CPA is often viewed as a summative process (DeYoung, 2009; Gaberson et al., 2015; McCutchan, 2010; Oermann & Gaberson, 2014; Reilly & Oermann, 1999; Reynolds, 2005).

This inquiry was positioned between two distinct disciplines: education and nursing. Therefore, an intentional merging of terms was done to ensure clarity and congruency of meanings. The use of the term *summative* implies *assessment of learning*

or assessment associated with a grade as opposed to *formative*, which implies *assessment for learning* and does not influence grades (Black & William, 1998). In the context of this inquiry, FA was defined as

> the collaborative processes engaged in by educators and students for the purpose of understanding the students' learning and conceptual organization, identification of strengths, diagnosis of weaknesses, areas for improvement, and as a source of information that teachers can use in instructional planning and students can use in deepening their understandings and improving their achievement. (Cizek, 2010, pp. 6–7)

Many concepts have different meanings in the education and the nursing literature. For example, in the education literature, assessment is defined as the process of gathering, interpreting, recording, and using information about teaching and learning for the purpose of supporting and enhancing the teaching–learning process (Andrade, 2010; Black & Wiliam, 1998; Boyle & Charles, 2014; Cizek, 2010; Earl, 2013; Gardner, 2012; Greenstein, 2010, 2012). In the nursing literature, the term assessment is commonly used to describe the gathering of objective and subjective information about patients (Gaberson et al., 2015). Furthermore, the terms assessment and evaluation are used interchangeably in the nursing literature (DeYoung, 2009; O'Connor, 2001; Oermann, & Gaberson, 2014), which adds to the ambiguity of defining the process of assessment for the purpose of enhancing learning. The difficulty in differentiating between assessment and evaluation processes is compounded by the fact that formative feedback and FA are routinely viewed synonymously in nursing education, and they are commonly used as evidence to support summative assessments included in the CPA to determine success in

clinical courses or to halt academic progression. Boyle and Charles (2014) stated, " there is the paradigm of *testing,* which is not the same thing as assessment – although the last decade might have made one think otherwise" (p. 4).

Evidence that the distinct nature of assessment and evaluation is not well defined in the nursing literature was found in Allen and Prater (2011), who noted "the purpose of formative evaluation is to provide specific and detailed feedback to the student and observe his/her ability or inability to integrate this feedback into his/her clinical practice" (p. 417). Knowing that formative assessment, more often than not, contributes to summative decisions in nursing education, this stated purpose overlooks the potential for learning from the formative feedback and points to the evaluative nature of CPA.

Interestingly, although Gaberson et al. (2015) strongly claimed that "the central activity of the student in clinical education should be learning, not doing" (p. 16), they refer to grading in clinical courses as the regular evaluation of student performance throughout the course rather than the assessment of learning. Similarly, Reynolds (2005) alluded to the practice of gathering summative evidence throughout the clinical experience when she stated that the clinical nurse faculty (CNF) "evaluates students by observing student performance and collecting written data; together, these strategies provide the CNF with varying amounts of information from which to make an evaluative judgment" (p. 6).

Concerns over the purpose of CPA are consistently identified as the most troubling dilemma for nurse educators as they continue to be challenged by the conflicting nature of clinical nursing experiences, namely, to foster learning and to determine whether the student can progress in the nursing program (DeYoung, 2009;

Gaberson et al., 2015; McCutchan, 2010; O'Connor, 2001; Reilly & Oermann, 1999; Wiles & Bishop, 2001). Dunn and Hansford (1997) recognized that "the clinical learning environment (CLE) is an interactive network of forces influencing students' learning outcomes in the clinical setting" (p. 1299). On the premise that clinical settings are ideal locations for students to learn from the experiential situations they encounter (Canadian Nurses Association, 2008; Gaberson et al., 2015; MacFarlane et al., 2007; Oermann & Gaberson, 2014; Ralph et al., 2009; Reilly & Oermann, 1999; Villeneuve & MacDonald, 2006) and acknowledging that assessment is a fundamental aspect of clinical nursing courses (McCutchan, 2010; Melo, Williams, & Ross, 2010; Sharif & Masoumi, 2005; Wiles & Bishop, 2001), this inquiry sought to explore the lived experience of nursing students and describe the phenomenon of being assessed in clinical nursing courses.

In 2010, the Faculty of Nursing at a midsize Canadian university mandated the formal integration of FA processes in all courses of its curriculum because FA and SA had not been clearly defined and integrated in the past, especially within clinical courses. In this context, FA was construed as a strategy used exclusively for the purpose of generating formative feedback to be used by teachers and learners with the intent to enhance learning. This was to ensure that both FA and SA would be used in classroom and clinical courses.

Because I always believed that FA contributes to enhanced teaching and learning processes, I was interested in understanding the impact of formally embedding FA into the learning experience of students in clinical courses. After reviewing the nursing and the education literature and discovering a paucity of research on FA in clinical nursing courses; I developed a research proposal aimed at exploring the lived experience of

nursing students with FA formally embedded in clinical courses using an adaptation of van Kaam's approach to transcendental phenomenology developed by Moustakas (1994). van Kaam (1959) directed users of his method to use a single question aimed at eliciting unconstrained, rich descriptions of subjective experience. The question guiding my inquiry was: How is the phenomenon of assessment experienced by nursing students when FA is formally embedded in clinical courses?

Although nursing students commonly experience the phenomenon of being assessed for the purpose of the CPA, no similar research was found in the literature. Hence, it was determined that uncovering nursing students' lived experience of being assessed in clinical courses where FA is formally embedded in the curriculum would address a significant gap in the nursing literature and would bring to the forefront the complex nature of CPA.

Personal Background and Theoretical Approach

I came to this research as a full-time nursing faculty member with advising, coordinating, and teaching responsibilities across the nursing curriculum. For the past 31 years, I have taught nursing in classrooms, laboratories, and various acute care settings. As a nurse educator, I recognize the centrality of learning in nursing education, and I strive to foster environments where active and collaborative learning can happen in all settings where nursing is taught. My teaching practices are directed at empowering students to take ownership of their knowledge construction with the goal of helping them to develop problem-solving and critical thinking skills that can be used to succeed in their nursing program and beyond. I believe that human beings learn and shape valuable knowledge from experience and from interpersonal interactions. Consequently, I view

learning as the deepening of current knowledge and the construction of new knowledge through active cognitive processes and interaction with the social world. Ultimately, I believe that experiential learning occurring under mutually respectful and empowering conditions can result in refined practical knowledge and enhanced professional competence.

Although I consider clinical experiences to be rich opportunities for learning, I am constantly challenged by my desire to foster student learning in clinical courses while remaining aware of my responsibilities and accountability to the university for grading student work. This is compounded by my moral and ethical obligation as a registered member of the nursing profession to ensure safe and competent care for the patients to whom I assign my students. Nevertheless, because I strongly believe in the potential of FA for enhancing the teaching and learning process, I consider the interactions between teachers and students in the clinical setting as mostly formative in nature, and I believe that the primary role of nurse educators is to guide students in their learning journey by allowing them space and time for learning. This belief was the catalyst for my engagement in doctoral studies and for this inquiry.

The fundamental importance of clinical experiences in nursing education is undisputed. According to Mannix, Faga, Beale, and Jackson (2006),

> planned clinical experiences are widely understood to provide students with opportunities for authenticating their knowledge, integrating theoretical and applied knowledge, developing and refining skills, familiarizing themselves with the nursing workplace and developing the problem solving and time management skills essential for registered nurses. (p. 3)

The fact remains that the process of CPA is fraught with challenges such as instructor subjectivity, and this has been widely addressed in the literature (Benner et al., 2010; Budgen & Gamroth, 2008; Dolan, 2003; Gaberson et al., 2015; Oermann & Gaberson, 2014; Reilly & Oermann, 1999). For example, Woolley (1997) alluded to the "long and tortured history" (p. 308) of clinical evaluation in nursing education and worried that the element of subjectivity in evaluation processes was the biggest challenge facing students and clinical teachers at that time. The current nursing literature continues to reflect concerns about the influence of teacher subjectivity in the assessment of clinical performance (Budgen & Gamroth, 2008; Del Prato, 2010; Cannon & Boswell, 2012; Dolan, 2003; Gaberson et al., 2015). As acknowledged by O'Connor (2001), "the instructor's observation of students as they carry out clinical assignments probably contributes most to the overall evaluation of students' clinical performance" (p. 185). DeYoung (2009) deplored the fact that current clinical teaching practices remain grounded in tradition and collective wisdom rather than research. While acknowledging the importance of clinical experiences, she described clinical teaching as a complex process and noted, "it is so complex that few researchers have tackled the issues that need to be addressed" (DeYoung, 2009, p. 239).

This research is situated in the field of cognition and learning with a focus on FA in baccalaureate nursing education. Many authors have recently called for changes to nursing education and believe that the time has come to rethink learning and assessment; to look at those concepts from a fresh point of view informed by research evidence based in nursing classrooms and practice settings (Anema & McCoy, 2010; Benner et al., 2010; Cannon & Boswell, 2012; DeYoung, 2009; Ellis & Hartley, 2008; Oermann & Gaberson,

2014). Through this study, I aspired to discover and describe nursing students' experience with FA formally embedded in clinical courses using a sociocognitive lens where interactions between students, clinical instructors, assessment tasks, and learning were explored.

Because my study focussed on FA and nursing students, it bears mentioning that I went through nursing education in the 1970s and experienced the process of CPA in all the clinical courses of my nursing program. Based on my experience of CPA as a student and as a nurse educator with 31 years of experience, I can attest that the process of CPA remains the same, as evidence from FA continues to be used for summative purposes. Further evidence substantiating this fact is provided in the literature review that follows in Chapter Two. I recall that as a nursing student, I viewed the classroom as the setting where theoretical content was taught and learned. For me, clinical experiences were the place where I had to show my instructors what I knew so that they could confirm that I was fit to continue in the program. Because I was a self-directed and assiduous student, I did not experience extreme levels of stress related to clinical experiences; however, I viewed clinical experiences as evaluative in nature and did not recognize the pedagogical nature of these experiences until I took undergraduate courses for my second degree, a baccalaureate in education. Interestingly, it is only when I transitioned from an acute care nurse to nursing teacher that I realized that, in the context of clinical nursing education, the boundaries between learning and testing are blurred and that it may lead nursing students to perceive clinical courses as testing arenas. This issue continues to fuel my desire to study the process of teaching and learning in clinical nursing courses.

Statement of the Problem

In the education literature, feedback is conceptualized as a FA strategy aimed at enhancing learning through identification of what students know and for guiding them in meeting learning goals (Andrade, 2010; Black & Wiliam, 1998; Earl, 2013; Gardner, 2012; Hattie & Timperley, 2007; Irons, 2008; Wiliam, 2011a). However, in the nursing literature, FA is often equated with the term feedback (Koh, 2010; McCutchan, 2010; Sharif & Masoumi, 2005; Stuart, 2007; Wiles & Bishop, 2001). Koh (2010) noted that FA is unclear to nurse educators and that they understand the concept as being the process of giving feedback to students in order to prepare them for summative assessment. Koh's (2010) claim is validated by statements such as Gaberson et al.'s (2015) suggestion that "clinical evaluation may be formative or summative" (p. 323) and De Young's (2009) explanation that "*formative* evaluation is the ongoing feedback given to the learner throughout the learning experience" (p. 253). By using the terms evaluation, formative, and feedback together, nurse educators continue to focus on the evaluative purpose of assessment and neglect to emphasize the significant potential for learning that assessment and feedback are attributed in the education literature. Another example of this was offered by Zsohar and Smith (2009), who defined verbal constructive feedback in nursing education as "oral input into performance for the purpose of correcting errors and enhancing learning" (p. 241). Although Zsohar and Smith acknowledged that constructive feedback can foster learning, their definition perpetuates the conceptualization of feedback as evaluative in nature and as a source of information about students' performance; it does not address the positive implications of this type of feedback on the teaching–learning process.

In nursing education, issues and gaps in knowledge discussed during informal FA, the content of any interactions between clinical instructors and students, and the content and feedback on any written assignment passed in during a clinical course are consistently used for the summative assessment of students' clinical performance (DeYoung, 2009). Hence, metaphorically, nursing students are being assessed summatively as soon as they set foot in the clinical setting, and student performance from the first day on clinical may be a determining factor in the summative grade for the course. Wilson (1994) explored the perspective of nursing students about learning in clinical settings and found that "students were constantly aware that the instructor was evaluating them" (p. 84). This implies that students may view the clinical setting as a testing ground rather than a space for learning where formative experiences and feedback could be used to enhance learning.

Nurse educators may feel that providing students with constructive feedback is doing FA; after all, the dialogic interactions taking place between teachers and students in the clinical setting are mostly formative in nature and they are aimed at guiding and enhancing student learning. However, students are assessed as they adjust to various clinical settings and as they learn to provide care to different patients whose conditions and responses to care are unpredictable. Hence, the fact that all assessment feedback may be used to assign academic grades in clinical courses leads me to question whether the formal practice of FA as defined by Cizek (2010) and by other authors in the education literature (Andrade, 2010; Black & Wiliam, 1998; Havnes & McDowell, 2008) may in fact be undertaken or even nonexistent in clinical nursing education. This concern fuelled my curiosity about the concept of assessment in clinical nursing education and

intensified my desire to understand the phenomenon from the perspective of nursing students.

The importance and value of FA in informing learning is clearly established in the education literature (Andrade, 2010; Bell & Cowie, 1999; Black & Wiliam, 1998; Cizek, 2010; Earl, 2013; Gardner, 2012; Greenstein, 2010, 2012; Wiliam, 2011a, 2011b). Despite FA being the topic of many studies on classroom-based nursing courses, there was no research found on the lived experience of students with FA formally embedded in clinical courses. Answering the question: How is the phenomenon of assessment experienced by nursing students when FA is formally embedded in clinical courses adds to the knowledge of FA in nursing education. Inherent in this question were the following issues: (a) the meaning of clinical experiences for nursing students, (b) the meaning of being assessed through FA, and (c) what it is like to be assessed when FA is formally embedded within clinical experiences.

Purpose of the Study

Nursing education is shaped by a social mandate to develop safe and competent nurses who can practice in dynamic and complex health care environments (Benner et al., 2010; Canadian Association of Schools of Nursing [CASN], 2010; Ellis, & Hartley, 2008; Gaberson et al., 2015; McIntyre & McDonald, 2014; Villeneuve & MacDonald, 2006). As the assessment discourse continues, increased attention will need to be put on fostering the development of higher thinking capabilities and attributes necessary to thrive in the 21st century and beyond (Benner et al., 2010; CASN, 2010; Del Prato, 2010; Gaberson et al., 2015; McIntyre & McDonald, 2014; Villeneuve & MacDonald, 2006). Having a solid base of content knowledge is no longer adequate; having a broad range of

abilities that can be used to adapt to the ever-changing demands of the societal context is critical in nursing, where maintaining patients' safety is a professional obligation and a moral imperative (Benner et al., 2010; CASN, 2010; Gaberson et al., 2015; McIntyre & McDonald, 2014; Moyer & Wittmann-Price, 2008; Villeneuve & MacDonald, 2006). As stated by Emerson (2007), "to prepare nurses who are equipped to enter nursing practice and further develop their clinical judgment, the teacher must nurture the novice" (p. 36), and the ideal location to do so is within clinical experiences where "theory literally comes alive" (p. 36). Therefore, besides being a fundamental aspect of nursing education, clinical courses remain integral to the preparation of tomorrow's nurses.

Clinical environments are rich settings for praxis, and the literature suggests that those settings may not be exploited to their full pedagogical potential (Cannon & Boswell, 2012; Gaberson et al., 2015; Melo et al., 2010; Sharif & Masoumi, 2005). This issue was the driving premise for this inquiry, as I posited that using all of the students' assessments conducted during clinical nursing courses for the summative evaluation of their performance may potentially hinder the teaching–learning process by blurring the boundaries between learning and testing. Dewey (1938) viewed s*urrounding conditions* as fundamental to knowledge construction. Of utmost importance to the context of clinical nursing education and to support the need for this study was the claim by Dewey that learning through experience results in deeper and lasting knowledge. In educational environments, such as clinical nursing placements, where the aim is to teach and learn how to practice nursing in a safe and competent manner and to foster the development of adaptable higher thinking skills, maximizing the learning environment through strategies such as FA may be valuable in fostering nursing students' construction of knowledge.

Due to the paucity of literature on the subject, it was concluded that this could be evidenced only through rigorous inquiry into the experience of nursing students with FA in clinical courses.

The belief that the effective use of FA leads to readjustment in the processes of teaching and learning for students and teachers and fosters deep learning was the basis of a faculty-wide decision in the Faculty of Nursing at the university where this study took place to consider the formal implementation of FA into all classroom and clinical courses. Following my presentation of a workshop on implementing a culture of assessment and after much discussion during curriculum revision sessions, the decision was made by faculty and supported by the dean to formally embed FA strategies in each course of the curriculum.

In the context of the curriculum at the university being studied, clinical courses are graded as a pass or fail at the end of the course. Before June 2010, all assessments done during clinical courses were used to complete a midway summative CPA and a final summative CPA, eventually combined to support the final grade. In 2010, the Nursing Faculty decided to formally integrate FA in all clinical courses. Consequently, they decided to stop the practice of using self-reflective assignments for summative purposes and mandated that guided reflections done by students in clinical settings would be used exclusively as FA. It was also decided that some of the written assignments integrated into clinical courses would become *formative* in order to increase the amount of FA within clinical experiences. Hence, to provide space for students to reflect on their practice in a forum that is not integral to the summative component of their CPA, guided reflection and other FA strategies such as concept maps have been formally embedded in

all clinical courses since the beginning of the fall 2010 academic term. The distinct nature of the formative assignments is communicated to new faculty and to students at the beginning of each clinical course since September 2010. The reflective facilitation framework developed by Gibbs (1988) was chosen as one FA strategy to be used by clinical teachers to help students reflect on their practice and integrate or construct knowledge from clinical experiences. Gibbs's guided reflection model asks cue questions such as (a) what happened? (b) what were you thinking and feeling? (c) what was good and bad about the experience? (d) what sense can you make of the situation? (e) what else could you have done? and (f) if it arose again, what would you do? Those questions are used by nursing students to reflect on practice situations that they encounter in various clinical settings, and clinical instructors use the reflections to guide students in their construction of deeper knowledge. The use of other FA strategies in clinical courses continues to be the responsibility and choice of individual clinical teachers. Examples of strategies that have been used formatively are concept maps and oral presentations.

As evidenced in the education literature, if used effectively, FA has the potential to enhance the teaching–learning process and consequently foster learning (Andrade, 2010; Black & Wiliam, 1998, 2009; Cizek, 2010; Earl, 2013; Gardner, 2012; Greenstein, 2010, 2012; Wiliam, 2010, 2011a, 2011b). The nursing literature on CPA is abundant and it frequently addresses the fact that FA is regularly integrated in summative assessments of clinical courses. This fact was iterated by Emerson (2007) when she stated that "evaluation of learning is ongoing from the initiation of the course" (p. 273). Since research uncovering the lived experience of nursing students with assessment in clinical courses where FA is formally embedded was not found, this research asked: How

is the phenomenon of assessment experienced by nursing students when FA is formally embedded in clinical courses? It sought to uncover the phenomenon of assessment for nursing students who had lived the experience and to describe the meaning of that experience as they perceived it.

Significance of the Study

Current and future challenges such as technological advances, globalization, progress in the field of genetics, changing disease patterns, and expanding knowledge opportunities significantly influence the health care system and consequently, nursing education. According to Benner et al. (2010), "the demands of practice are such that the professional must learn constantly and integrate knowledge, skilled know-how, and ethical comportment" (p. 10). They believed that today's rapid and dynamic demands on the health care system create a fundamental force leading to the need to reform nursing education. In calling for sweeping changes to nursing education that would ensure a nursing workforce able to meet present and future needs of the health care environments, Benner et al. claimed that "redesigning nursing education is an urgent societal agenda" (p. 16). Other nursing leaders also identified a pressing need to reform and update nursing education (Anema & McCoy, 2010; Cannon & Boswell, 2012; Del Prato, 2010; Oermann & Gaberson, 2014; Villeneuve & MacDonald, 2006). This inquiry explored current nursing education practices as described in the literature and aimed to describe the phenomenon of assessment from the perspective of nursing students who had FA formally embedded in their clinical courses. Because it focuses exclusively on clinical courses, this study contributes to reduce our reliance on assumptions derived from

research on formative assessment in nursing classrooms and provides evidence based on the reality of using formative assessment in clinical courses.

Definition of Terms

Because the findings of this inquiry may be used by other professional disciplines where practical experiences are integrated, and because the research addressed a phenomenon related to nursing education, it is important to define common terms specific to this study to ensure congruency of meanings. The following are terms commonly used in the nursing education literature related to clinical courses.

Nursing Practice

The profession of nursing offers various career opportunities within distinct paths such as clinical care, education, research, and administration (Gregory, Raymond-Seniuk, Patrick, & Stephen, 2015). In the context of this research and throughout this dissertation, nursing practice refers to clinical care, unless specified otherwise. It is important to note that the term *practice* is used as a noun; therefore, it refers to the practice of nursing or nursing practice.

Clinical Care

In this dissertation, clinical care refers to the provision of nursing care within various clinical settings. Nursing care includes nursing interventions guided by safe and ethical practice as well as critical thinking. Such interventions include, but are not limited to, assessments, basic physical care, treatments and procedures, interpersonal relationships, and so forth. An important aspect of nursing practice and clinical care assumed in this dissertation is that

> nurses accompany patients who live with disease or conditions, both chronic and acute, helping them live as fully as possible despite their ailments. Nurses are there in the care of the dying. Nurses are there promoting the health and well-being of clients, families, groups, and communities. Nurses come to know fully the human condition. Through encounters with patients and clients, they are empathic witnesses to joy and sorrow, life and death, and the frailty and resilience of the human body and spirit. Nurses are also present with patients and clients as highly educated, knowledgeable, ethical, and skilled care providers. (Gregory et al., 2015, pp. 4–5)

Clinical Settings

Clinical settings include on-campus clinical and off-campus clinical. On-campus clinical may include, but is not limited to, locations such as conference rooms, classroom space, and psychomotor skills laboratories. Off-campus clinical may include, but is not limited to, acute care facilities such as hospitals, community locations such as client homes and schools, and various community agencies.

Clinical Experience

In nursing education, the concept of clinical experience relates to activities within various clinical settings that facilitate the learning of nursing students. The following definition by Woodley (2015) is congruent within the context of this study: “The clinical experience offers nursing students the opportunity to apply theory from the classroom setting into the practice setting” (p. 142). Theory learned in psychomotor skills laboratories and from other sources can also be integrated into the clinical experience to enhance learning. Hence, throughout the manuscript, the term clinical experience

encompasses any activities and tasks happening within clinical settings aimed at giving students opportunities to learn to become nurses.

Clinical Course Grade

Clinical course grade is the summative value that confirms whether a nursing student was successful in the course and can continue to the following clinical course. For the purpose of this dissertation, the clinical grade is "a symbol (A through F, pass–fail) that represents the student's achievement in a course" (Oermann, 2015, p. 192) and determines a student's fitness to progress in the nursing program.

Outline of the Remainder of the Document

This chapter introduced the problem central to this inquiry and provided background information to convey the theoretical underpinnings of the study. Definitions specific to the inquiry were presented and the significance of the study was discussed.

In Chapter Two, an integrative review of the nursing and education literature guiding the development of the research proposal for this inquiry is presented. A synopsis of the literature review supporting the relevance and the timeliness of the research for nursing education is provided.

Chapter Three presents the philosophical underpinnings of the study and reasons for choosing the "Modification of the Van Kaam Method of Analysis of Phenomenological Data" (Moustakas, 1994, p. 120). Key concepts and processes of the transcendental phenomenology approach developed by Moustakas (1994) are described, and details related to the process of data analysis are explained. Specific examples of phenomenological descriptions are used to illustrate the research process leading to the textural and structural descriptions of the lived experience of participants. A creative

synthesis revealing the essences and meanings of the co-researchers' experience with assessment in clinical nursing courses is presented. Information regarding the selection of sites and participants, instrumentation, and ethical considerations related to the inquiry are discussed.

Chapter Four presents the findings, and the essence of the phenomenon of assessment as uncovered from co-researchers' accounts is explained. The *noema* and *noesis* of the phenomenon explored in this inquiry were universal to each co-researcher. The noematic themes that illuminated what it was like for nursing students to experience assessment in clinical courses where FA was formally embedded were (a) enabled cognitive activity, (b) useful feedback, (c) freedom to be, (d) enhanced focus, (e) stress moderator, and (f) respectful mentorship. The noetic themes that explained how the phenomenon was experienced were related to bodyhood, temporality, spatiality, and relationship to others.

In the last section, Chapter Five, the findings are discussed in relation to the literature. Limitations of the research, implications for future research, and the potential personal and professional ramifications related to the study are presented.

Moustakas's (1994) research approach consists of a sequential methodological framework for conducting transcendental phenomenological human science research. The detailed framework included in Appendix A was followed to ensure the methodological integrity and rigor of this inquiry. The next chapter is the literature review used to situate the problem and develop the research proposal for this study. Further review was conducted following data analysis to correlate the findings to the literature, and it is presented in Chapter Five.

CHAPTER TWO: REVIEW OF THE RELATED LITERATURE

This inquiry is situated in the naturalistic paradigm. To prevent the views and perspectives of others from influencing researchers' objectivity, some authors discourage an extensive review of the literature at the beginning of a qualitative study (Creswell, 2008; Frankel, 1999; Streubert & Carpenter, 2011; van Manen, 1984, 1997). Munhall (2012) identified the literature review as a source of contention in qualitative research such as grounded theory and claimed "the rationale for not conducting an extensive literature review earlier is to avoid beginning the study with pre-conceived ideas" (p. 231). Similarly, although Lichtman (2006) posited that a comprehensive literature review is critical to understanding the state of the knowledge, she agreed that it might sway the qualitative researcher's perception and influence the way the data are explored. Thus, she claimed that a brief review of related literature should still be an integral component of the initial preparation of a qualitative research project but cautioned that it should not be so comprehensive as to influence the descriptions, understandings, and interpretations of the researcher. Streubert and Carpenter (2011) suggested that phenomenological researchers should delay the literature review until after data analysis is complete or when the phenomenon is elucidated. They explained that in phenomenological research, the literature review "is not meant to confirm or argue existing findings" (Streubert & Carpenter, 2011, p. 26), but it serves to demonstrate "how the findings fit with what is already known about the phenomena" (p. 26). They believed that "postponing the literature review until data analysis is complete facilitates phenomenological reduction" (Streubert & Carpenter, 2011, p. 84) and, therefore, they

viewed the literature review done following the process of data analysis as more valuable and as a unique aspect of phenomenological inquiry.

Referring to different types of literature reviews such as integrative, theoretical, methodological, and thematic, Moustakas (1994) explained that "the integrative review presents the 'state of the knowledge' relevant to a topic and draws conclusions from the many separate studies that are reviewed" (p. 112). For this inquiry, an integrative review of the literature was undertaken to situate the context of the study, to identify gaps, to justify the need for exploring the lived experience of nursing students with FA formally embedded in clinical courses, to understand various concepts related to FA and clinical nursing education, and to develop the research proposal. Further review of the literature was conducted following data analysis and is included in Chapter Five.

A literature search covering a 10-year period from 2000 to the year 2010 was done. Key databases, such as the Cumulative Index to Nursing and Allied Health Literature (CINAHL), ProQuest Dissertation & Thesis, the Education Resources Information Center (ERIC-EBSCO), Google Scholar, and the Social Sciences Citation Index (SSCI) were searched using the following key terms: *assessment*, *nursing education*, *clinical performance appraisal*, and *formative assessment*. Because of the paucity of nursing literature on FA in clinical courses, further search was conducted adding the years 1995 to 2000 and the key words *nursing student* and *clinical*. In all, the search yielded 54 research articles and two dissertation theses. Of those, the dissertation theses and 11 articles were deemed pertinent as they focused on the clinical experiences of nursing students. Of the 11 articles, nine were qualitative studies and two were quantitative studies. Both dissertation theses were qualitative studies. Only one of the

articles addressed the issue of nursing students' experience of FA in classroom and psychomotor skills laboratory. This confirmed a significant gap in the nursing literature and supported the significance of this study.

The following section provides a snapshot of the nature of nursing education beginning with the development of nursing knowledge and clinical nursing education. The complex nature of CPA is explained. The impact of strategies commonly used during the process of CPA, which include self-assessment, feedback, and guided reflection, is discussed. The concept of FA is presented last to segue the remaining parts of this manuscript. After presenting FA as a process and as a teaching–learning strategy, the definition of FA guiding this inquiry is used to close the literature review and transition into the methodological section of the dissertation.

Nursing Knowledge

Understanding and explaining the unique knowledge used by nurses to guide their practice is more than listing the theoretical content accumulated during formal education programs; it is a complex process that is still being studied today (Benner et al., 2010; Chinn & Kramer, 2011; Rodgers, 2005). For many, knowing in nursing is viewed as an active and shifting process influenced by the personal perspective of the nurse engaged in dynamic nursing situations and contexts (Benner, 1984; Carper, 1978; Chinn & Kramer, 2011). This implies that the manner in which nursing knowledge is developed uncovers how nurses come to know and how they transform knowledge borrowed from other disciplines to guide their nursing practice. In their attempt to define nursing knowledge, Chinn and Kramer (2011) suggested that

> the knowledge of a discipline is knowledge that has been collectively judged by standards that are shared by members of the disciplinary community and that is taken to be valid and accurate understanding of elements and features that comprise the discipline. (pp. 3–4)

Regrettably, what constitutes nursing knowledge and how it is developed is still the subject of debate amongst nursing scholars.

Prior to the emergence of formal education; apprenticeship was the main approach for educating learners about practice fields (Choi & Hannafin, 1995). The historical roots of nursing are grounded in hospitals where knowledge was imparted through an education model based on apprenticeship. In this model, nurses assumed the sole responsibility for teaching nursing students in hospital settings. Over time, the responsibility for nursing education shifted from hospital programs to academic institutions; however, hospitals remain key environments where nursing knowledge is constructed and refined. As posited by Budgen and Gamroth (2008) "classroom, simulation and laboratory experiences make essential contributions to students' knowledge and skill development. Experience in actual settings is an additional, irreplaceable component" (p. 274).

Dewey (1938) described knowledge development or learning as a process of making connections. He viewed schools as social institutions where the social and interactive processes of teaching and learning take place. Consequently, he defined education as a humanizing process in which established members of a social group assist learners in their development of specific knowledge through particular social interactions. He recognized the importance of learning in context or situated learning, which he termed

"surrounding conditions" (Dewey, 1938, p. 68). Emphasizing that the concept of environment includes more than the physical nature of the setting, Dewey drew attention to the fundamental contribution of the participants associated with particular social situations. He asserted that once the neophyte becomes part of a particular social group, awareness of the beliefs, tools, and goals of the group become assimilated to form the basis of a new knowledge base (Dewey, 1938).

Similarly, in the situated cognition literature (Brown, Collins, & Duguid, 1989; Choi & Hannafin, 1995; Stein, 1998, Wenger, 2000), the nature of learning is directly linked to the environment or context in which it is acquired. Situated cognition, as defined by Brown et al. (1989) is inherent within clinical nursing education. Nursing students are immersed into practice cultures with clients, and they engage in learning with and from experts (Carper, 1978; Field, 2004; Gaberson et al., 2015; Lynaugh, 2007; McCutchan, 2010; Reilly & Oermann, 1999; Reynolds, 2005). Brown et al. (1989) described situated learning as a *process of enculturation*. They maintained "to learn to use tools as practitioners use them, a student, like an apprentice, must enter that community and its culture. Thus, in a significant way, learning is, we believe, a process of enculturation" (Brown et al., 1989, p. 33). In her study of the value of learning in clinical practice, Field (2004) also referred to the process of enculturation when she stated "part of the student nurse's enculturation in a clinical setting was learning how procedures were actually carried out in the *real* setting" (p. 563). Benner (1984) and Carper (1978) don't use the term *enculturation* to refer to the process of learning in clinical settings; however, they acknowledged the value of situated learning in nursing and alluded to its fundamental importance for the development of nursing knowledge.

To define the process of knowledge development in nursing, Benner (1984) used the model of skill acquisition developed by Dreyfus and Dreyfus in the 1980s to explore how nurses with varied levels of nursing experience reacted to the unpredictability of their patients' nursing care needs. As a result, she uncovered a specific process of meaning making and knowledge development, which she placed on a continuum of novice to expert similar to the Dreyfus and Dreyfus model. Although she valued the importance of a comprehensive theoretical base in nursing, Benner recognized the fundamental value of practical knowledge gained from situated learning experiences. She stated that "knowledge development in an applied discipline consists of extending practical knowledge (know-how) through theory-based scientific investigations and through the charting of the existent 'know-how' developed through clinical experience in the practice of that discipline" (Benner, 1984, p. 3). This distinction made by Benner regarding the difference between theoretical knowledge and practical knowledge is similar to Polanyi (1966), who referred to theoretical knowledge as explicit or "knowing that" (p. 7) and to practical knowledge as implicit, tacit, or "knowing how" (p. 7). Interestingly, although Benner made a clear distinction between explicit and tacit knowledge, Polanyi saw them as interrelated.

Carper (1978) identified four fundamental patterns of knowing used by nurses in their holistic practice of nursing as: *empirical knowing*, *aesthetic knowing*, *ethical knowing*, and *personal knowing*. She believed that nursing involved a dynamic process of interactions guided by four fundamental types of knowledge necessary to practice as a nurse. In her seminal article, she reminded us that by understanding the four fundamental patterns of knowing used by nurses in their practice, we can better understand the

intricacies and breadth of nursing knowledge. For Carper, *empirical knowing* draws on factual knowledge from science and contributes to evidence-based nursing practice. She believed that *aesthetic knowing*, or "the art of nursing" (p. 15), is related to nurses' ability to perceive and interpret the nature of a clinical situation accurately and respond competently. She viewed *ethical knowing* as the moral compass of nurses and the knowledge that guides and directs how nurses conduct their own practice. Last, she described *personal knowing* as the basis for nurses' therapeutic use of self when caring for patients. To this day, many authors consider Carper's patterns of knowing "the epistemology of nursing" (Zander, 2007, p. 8).

In an attempt to understand and explain the nature of nursing knowledge and how it is developed, many nursing scholars have put forward additional ways of knowing in nursing. For example, White (1995) considered the influence of context to the development of nursing knowledge. She refers to "socio-political knowing" (p. 82) as a fifth pattern of knowing fundamental to understanding Carper's patterns. In this pattern, White took into consideration the all-encompassing context in which nursing and health care occur. She explained that "the other patterns address the 'who,' the 'how,' and the 'what' of nursing practice" (White, 1995, p. 82) and suggested that the pattern of *sociopolitical knowing* addresses the "wherein" (p. 82). Chinn and Kramer (2011) expanded on the sociopolitical knowing pattern identified by White (1995) and called it *emancipatory knowing* or the integration of social, political, and cultural knowledge necessary to "reduce or eliminate inequality and injustice" (Chinn & Kramer, 2011, p. 5) through praxis.

In 1982, recognizing the broadening scope of knowledge and skills required to practice nursing; the Canadian Nurses Association (CNA & CASN, 2004) mandated the baccalaureate degree in nursing as the minimum requirement for entry to practice in Canada. As reminded by McIntyre and McDonald (2010), "the baccalaureate degree as entry to practice for RN's demonstrates how the profession has responded to a more complex healthcare system that requires greater depth and breadth in nursing knowledge than was previously required" (p. 184). Nurses are respected not only for what they do but because of the knowledge they use to substantiate their actions (Benner et al., 2010). Relational knowledge, or the knowledge developed from and within caring relationships with clients, as well as contextual knowledge, the knowledge grounded in the nurses' life and practice experiences, are important and integral aspects of nursing practice. Interestingly, the relational and contextual knowledge derived from nursing practice have remained largely unarticulated, and this has contributed to the ambiguity surrounding the definition of nursing knowledge (Benner, Tanner, & Chesla, 2009; Chinn & Kramer, 2011; DeYoung, 2009; Dolan, 2003). This research into the lived experience of nursing students with assessment brings to light the process of knowledge development in clinical settings from the students' perspective.

Clinical Nursing Education

Given the practical nature of the nursing profession, clinical experiences are central to the development of nursing knowledge and contribute to the socialization of nursing students (MacFarlane et al., 2007). In the nursing literature it is suggested that the integration of theory and practice into real-life clinical experiences fosters the development of nursing knowledge and competence (Benner, 1984; Benner et al., 2010;

McIntyre & McDonald, 2010). Hossein, Fatemeh, Fatemeh, Katri, and Tahereh (2010) referred to clinical teaching as "the cornerstone in nursing education" (p. 8). Clinical nursing education presents specific challenges that may not be significant in other teaching situations. McNeish (2011) explained that "clinical learning situations often involve '*a level of danger*' in '*dealing with people's lives'* where '*there's very little room for mistake"*' (p. 203). The fact that patients are directly involved in the teaching and learning situation of nursing students adds complexity to the process and necessitates that patient safety takes precedence over teaching and learning (Hossein et al., 2010; Villeneuve & MacDonald, 2006). Benner et al. (2010) acknowledged the complexity of nursing education and urged nurse educators to further integrate classroom and clinical teaching in order to strengthen the connections between the construction and use of knowledge leading to deeper meanings and competent nursing practice.

The complexities of the current and future challenges facing nursing education are unprecedented (Benner et al., 2010, Villeneuve & MacDonald, 2006), and the literature abounds with predictions regarding the health care system of the future including the knowledge and abilities that will be necessary to practice nursing in such environments (Ellis & Hartley, 2008; Haynes et al., 2004; McIntyre & MacDonald, 2010). Rodgers (2005) affirmed this as follows:

> With solid skills of reasoning and critical analysis and with an open mind to possibilities as yet unknown, nursing can proceed toward developing knowledge that meets the needs of the discipline, that places knowledge at the forefront of human inquiry, and that has the potential to make significant contributions to the creation of positive environments and the promotion of human health. (p. 207)

With this in mind, Villeneuve and MacDonald (2006) suggested that for nurses to thrive in future nursing practice environments, they must be taught in their nursing programs the skills and ways of knowing required to practice safely and efficiently in the future.

In most current nursing programs, the responsibility for choosing and tailoring the clinical experiences of students rests on the nurse educator who assigns patients according to each student's level of competence and theoretical knowledge (DeYoung, 2009; Reilly & Oermann, 1999). Decisions regarding clinical sites and characteristics of assigned patients, which can be viewed as "surrounding conditions" (Dewey, 1938, p. 68), must be made carefully and methodically to maximize the learning experience and maintain patient safety (Case & Oermann, 2004; DeYoung, 2009; Field, 2004). Today's nursing programs are challenged by increasingly complex health care environments where patients are much sicker and medically unpredictable. Furthermore, the emergence of interdisciplinary programs needing clinical placements for their students adds to the complexity of securing adequate clinical environments where nursing students can learn (Anema & McCoy, 2010; Cannon & Boswell, 2012; Del Prato, 2010; Oermann & Gaberson, 2014; Villeneuve & MacDonald, 2006). These dilemmas challenge the field of nursing education to consider innovative teaching strategies so as to ensure that nursing graduates have the opportunity to construct nursing knowledge and to develop the abilities necessary to provide safe and competent nursing care in dynamic environments and situations.

In the course of their clinical experiences, nursing students are required to deliver patient care within their scope of practice under the supervision of a clinical instructor. Students are expected to assess patients, to develop and implement individual plans of

care tailored to their assigned patients' needs, to administer medications and execute treatments as ordered, and to evaluate the outcomes of their care. Through those activities, student nurses are expected to integrate theoretical knowledge learned in classrooms, in the psychomotor skills laboratories, and from previous clinical courses in order to construct deeper knowledge of safe and competent nursing practice (Hossein et al., 2010; Stuart, 2007; Young & Maxwell, 2007).

Clinical Performance Assessment

The terms CPA and clinical evaluation are used interchangeably in the nursing literature (DeYoung, 2009; O'Connor, 2001; Stuart, 2007), and it often involves formative and summative assessments combined to make decisions on final grades (Arthur, 1995; DeYoung, 2009; Lasater, 2011; Pavlish, 1987). The faculty-supervised model of clinical education is the oldest and most universally used model in nursing curricula (Moyer & Wittmann-Price, 2008). In this model, a clinical instructor, who is usually a nurse educator in the nursing faculty, is responsible to teach and supervise groups of six to 12 students in specific clinical settings where students are expected to provide nursing care to patients assigned to them by the teacher. Generally, the day before a clinical experience, the instructor assigns one or two patients to each student, who is then required to access the assigned patients' charts and other resources to gather information about the nursing care required and other pertinent information needed to be prepared to care for those patients the next day. However, with the emergence of privacy legislations in Canada, some nursing programs are reconsidering the practice of gathering patient information prior to the clinical encounter between patient and student.

The day of the experience, the instructor provides direct supervision to students with the aim of guiding them in their learning construction while they interact with their patients, perform psychomotor skills, and demonstrate their knowledge through nursing practice. In addition, on a weekly basis, students are expected to complete various written assignments such as care plans, teaching plans, reflections on practice, and other relevant work to provide evidence of their critical thinking and growing knowledge. Instructors' written and verbal feedback is given while in the clinical setting as well as during weekly student–instructor meetings (DeYoung, 2009; Stuart, 2007).

At the end of a clinical rotation or the clinical course, nursing students are graded on their performance and on evidence of having met the learning outcomes for the course (Moyer & Wittmann-Price, 2008; Reilly & Oermann, 1999). The evidence used to assign a grade to clinical courses is comprised of various sources besides faculty observation and anecdotal notes of students' practice in the clinical setting. It may include all written work submitted by students, such as care maps, clinical worksheets, self-reflections, and portfolio content, if the latter is part of the course outcomes (DeYoung, 2009; Reynolds, 2005; Stuart, 2007). Pavlish (1987) claimed that nursing students should not be evaluated summatively in the clinical area until they have had the opportunity to adjust to the setting. Reynolds (2005) agreed that the CPA "should not begin with the student's first step onto the nursing unit" (p. 8), because it puts the focus on grades rather than on learning. Wiles and Bishop (2001) explored the concerns of students and clinical instructors over the process of CPA and discussed a criterion-referenced tool developed to assess clinical performance. They found that students favoured a more formative process but that they were reluctant to ask questions for fear of having their knowledge

base deemed inadequate. Overall, participants within their study viewed the process of CPA as an evaluative process and overlooked the learning opportunities that could derive from CPA.

Reynolds (2005) identified many problematic issues with the CPA process in nursing education. She criticized the fact that the number of students per clinical group is getting larger, which adds to the complexity of the clinical appraisal process, and she pointed to the flagrant lack of consistent guidelines for the process. Furthermore, Reynolds condemned the fact that although a student may perform outstandingly well in many of the clinical course objectives or outcomes, one error or even a potential mistake in patient care may jeopardize the student's success and result in an unsatisfactory grade. This situation points to the evaluative nature of clinical courses and exposes a flagrant flaw of the performance appraisal process that needs to be explored further through research. Although clinical environments are clearly described in the literature as exceptional grounds for learning, the fact that the pedagogical potential of clinical environments is hindered by a CPA process grounded in past practices rather than being guided by sound educational theory is also reported. DeYoung (2009) suggested that most of the current practices in nursing education are grounded in tradition and collective wisdom. She maintained that the time has come to explore the complex issues associated with clinical nursing education through formal inquiry in order to ensure that future pedagogical decisions are based on rigorous research evidence. This call was echoed by Benner et al. (2010).

Self-Assessment

Self-assessment is an integral aspect of the teaching and learning process in nursing education, especially in clinical courses. Guided reflection is a commonly used strategy for self-assessment in nursing education (DeYoung, 2009; O'Connor, 2001; Stuart, 2007). Sadly, DeYoung (2009) suggested that nursing students view guided reflections as an academic activity rather than a strategy to enhance learning and to foster change in practice. She stated that "when learners are given guidance in how to complete the self-assessment, and when helpful feedback on the content and thoughtfulness of the assessment is given, self-assessment becomes a learning activity and not merely an academic task likened to a chore" (DeYoung, 2009, p. 229). Hence, DeYoung suggested that nursing students need to be taught the process and the purpose of self-assessment in order to maximize its pedagogical purpose.

Andrade (2010) examined the concepts of self-assessment and self-regulation as they relate to FA and described them as complementary processes that can positively contribute to academic success. To prevent confusion with self-reflection, where the goal is self-discovery and self-understanding, she defined self-assessment as a "task-specific" process where "students reflect on the quality of their work, judge the degree to which it reflects explicitly stated goals or criteria, and revise accordingly" (Andrade, 2010, p. 92). Andrade recognized that self-regulation is characterized by an active involvement in one's learning and by the effective use of strategies and approaches to promote learning. She identified students as a worthy source of FA information and claimed that self-regulation, as well as self-assessment, can be developed and performed by most students. Black (2001) also posited that most students can learn the skills of self-assessment and

self-regulation; however, he warned that clear learning goals and collaborative teacher–student relationships must be present in order to foster active student engagement in the learning culture and enhance the construction of deep knowledge.

Walser (2009) pointed to the positive consequences of involving students in their own learning through self-assessment. She suggested that increased student responsibility for learning and enhanced collaboration between students and teachers are some of the benefits related to a culture of assessment where students' involvement is valued. Interestingly, Walser pointed to the limited use of self-assessment in higher education and deplored the fact that research around the issue remains scarce.

The widespread use of self-assessment in clinical nursing courses can be construed as an ideal forum for FA because it offers the opportunity to guide students in their knowledge construction. However, because students' self-evaluations are considered an integral part of the summative assessment, the benefits associated with completing a self-evaluation may be negated. Best, Carswell, and Abbott (1990) stated that "self-evaluation should play a part *only* in formative evaluation. This however, is not the case in nursing education today" (p. 172). They believed that summative assessment should remain an independent and separate entity leading to a course grade and that FA data should be used to guide students in their learning. Arthur (1995) presented preliminary research findings of an empirical study on the use of student self-evaluation in classroom-based courses. She explained that after concluding that self-evaluation can foster the development of skills and abilities of lifelong learning if used as a FA strategy exclusively, the faculty at a well-established nursing program in Ontario decided to

change their practice of using data from students' self-evaluations to support summative grades and to focus exclusively on the formative attributes of the assignment.

The practice of using FA data to support the summative assessment of nursing students remains a problem in many curricula. As reminded by Stuart (2007), "while they are adjusting to clients, staff and other personnel and also learning to perform care, we are assessing and giving them feedback on their performance. This means that while the student is learning she is being assessed" (p. 18). Authors such as DeYoung (2009) and O'Connor (2001) agree that all assessment evidence can be used to assign clinical course grades; however, this review of the literature points to the likelihood that using self-reflections as one of the components of summative assessment in clinical nursing courses negates the formative nature of the self-assessment process. As reminded by Oermann and Gaberson (2009), certain assessment strategies are aimed at generating summative evidence to support final grades and some are formative in nature; the latter should not be incorporated in the grade. This assumption was the driving force in the decision of the Nursing Faculty at the university chosen for this study to formally embed FA into their curriculum.

Feedback

Ramaprasad (1983) defined feedback as the evidence about a gap between what is known and what is expected to be learned that is used to alter that gap. In this definition, feedback is defined by its function of addressing gaps in knowledge rather than by the nature of the information it offers. Wiliam (2011b) warned that

> as soon as the term '*feedback'* is used to denote simply any data about the gap between current and desired level of performance, or worse, simply for

> descriptions of the current level of performance, it loses all connection with its original, and powerful, meaning. (p. 4)

Black and Wiliam (1998) wrote extensively about the fundamental influence of feedback on learning and student achievement. They suggested that although FA fosters student learning, the effectiveness of the strategy depends on the effective interpretation and use of feedback by teachers and learners. When referring to FA in their widely cited review of the literature, Black and Wiliam suggested that

> it is to be interpreted as encompassing all those activities undertaken by teachers, and/or by their students, which provide information to be used as feedback to modify the teaching and learning activities in which they are engaged. (p. 8)

Andrade (2010) viewed feedback as one of the most influential factors in student learning. She praised the value of teacher feedback but argued that feedback derived from self-assessment and from peers has greater potential for learning and for the academic success of students. Likewise, Hattie and Timperley (2007) claimed that valuable feedback can stem from others, such as teachers and peers, but also from the learners themselves. They emphasized that feedback "does not happen in a vacuum" (Hattie & Timperley, 2007, p. 82); it must be related to a specific context or performance.

Wiliam (2011b) acknowledged the value of feedback but added that "understanding the impact that assessment has on learning requires a broader focus than the feedback intervention itself, particularly the learner's responses to the feedback and the learning milieu in which the feedback operates" (p. 3). He further claimed that giving feedback on current performance or achievement is less effective than providing feedback that engages students in conscious self-assessment and guides them in

constructing deeper knowledge. Boud and Falchikov (2006) maintained that feedback is an important catalyst for learning but that its influence is dependent on many factors such as timing, context, and relevance. They discussed various studies in higher education where results showed that feedback is often provided too late to affect learning and that it consistently lacks in constructive comments. Boud and Falchikov further claimed that current assessment practices in higher education do not prepare learners to meet their own learning needs in the future and that these practices should be aimed at preparing learners for survival in dynamic environments where they will be required to continue learning if they are to progress and be successful.

The nursing literature on feedback is abundant; however, its definition remains unclear and often incongruent with the conceptualization of feedback found in the education literature. For example, Clynes and Raftery (2008) categorized feedback as "constructive/corrective/negative," "reinforcing/positive," and "opportunistic/on the spot" (p. 406). They suggested that because opportunistic feedback is an integral "part of the day-to-day activity of the clinical environment" (Clynes & Raftery, 2008, p. 406), it needs to be clear to students that this particular feedback is aimed at helping them improve their practice and is not just a vehicle for praise or judgment. Interestingly, the characterization of constructive feedback as negative feedback further confirms the peculiar conceptualization of the term in nursing education and seems to result in a common misunderstanding of FA as a process without reference to its purpose or potential for learning. Furthermore, the nursing literature propagates a widespread conceptualization of FA as feedback. In a study of nurse educators' perspectives of FA, Koh (2010) explained that her participants (n = 20) understood the primary purpose of

FA as "to give students feedback on their progress in preparation for the summative assessment" (p. 206), and she concluded that FA is often misunderstood by nurse educators.

The impact of feedback on learning is evident in the education literature (Andrade, 2010; Black & Wiliam, 1998; Boud & Falchikov, 2006; Hattie & Timperly, 2007; Irons, 2008; Sadler, 1989). Pollock (2012) claimed that "feedback can be the hinge factor for improving learning" (p. 3). She suggested that reflection on feedback fosters learning through assimilation of the feedback received and that it contributes to the acceptance and use of that feedback to construct new knowledge or deepen it. Ultimately, Pollock viewed reflection as a bridge between getting and using feedback to enhance learning. Considering that the potential of feedback is influenced by the ways it is given and received (Hattie & Timperley, 2007), it is evident that reflection fosters introspection and becomes a process through which learners intrinsically decide to accept and use the feedback offered or to ignore it.

Guided Reflection

Critical reflection is one of the main pedagogical tools used to bridge the theory–practice gap in nursing education (DeYoung, 2009; Fitzgerald & Chapman, 2000; Johns, 2000; O'Connor, 2001; Stuart, 2007; Taylor, 2000). At the university where I teach, the strategy of guided reflection is used as a FA strategy to foster learning through reflective practice. Although educational academics, such as Mezirow (1966, 1991) and Schön (1987), acknowledged the potential of reflection as a tool for learning, MacKintosh (1998) viewed it as a "flawed strategy" (p. 553) for nursing education and criticized its lack of a universal definition and undefined benefits for the profession. Rogers (2001)

explored the concept of reflection and found a plethora of terms used to describe the reflective process in the literature. He noted that the term reflection was used as a noun, a verb, an adjective, a process, and/or an outcome and that this adds to the ambiguity in determining the intended meaning of reflection in some of the teaching and learning sources that he consulted.

The use of guided reflection in nursing education implies that teachers guide students in reflecting on their practice or on specific critical incidents encountered during their clinical experiences. Although Fitzgerald and Chapman (2000) claimed that reflection contributes to the enhancement of the quality of professional nursing practice, they also identified a lack of empirical evidence to support that reflective practice results in better nursing care. Nevertheless, Maclellan (2004) viewed assessment for its "primarily formative function" (p. 312) and suggested that assessment strategies that provide students with formative responses to their performance may foster the development of important skills such as the skills of conceptualization and analysis as opposed to only the ability to remember concepts for the purpose of summative assessments.

Duffy (2009) commented on the scarcity of nursing literature on guided reflection and conducted a descriptive study to explore the process of guiding students through reflective practice with seven nursing teachers. In this study, guided reflection emerged as a valuable teaching tool to help students develop introspective, analytical, and reflective skills. Ash and Clayton (2004) viewed guided reflection as a strategy to gather written material from students that can be used to assess them formatively or

summatively, and they recognized its potential for maximizing experiential learning. They explained that

> whatever the forum for reflection, the *articulating learning* phase brings each reflection activity to a close and establishes a foundation for learners to carry the results of the reflection process forward beyond the immediate experience, improving the quality of future learning and of future experience, (related to service or to other aspects of their lives). (p. 142)

Johns (2000) discussed various reflective frameworks focusing on reflection as a cognitive activity for nursing and clinical courses. He maintained that regardless of the framework used, guided reflection becomes a developmental process where experiences are brought to consciousness through specific questions and used to construct new or deeper knowledge.

One of the most familiar reflective frameworks used in nursing education is that of Gibbs (1988). This cyclical reflection model is comprised of specific steps to guide learners in their reflective process. Through specific questions, learners are prompted to describe an experience or critical incident and to tease out the most salient points. They are then guided in identifying feelings associated with the experience and to evaluate perceived gaps and strengths that contributed or hindered knowledge construction and influenced the quality of their practice. Through continued reflection, learners are expected to analyze the situation and the knowledge that was used and to consider alternatives that could have been used or could be used in the future to enhance practice. Further evaluation of change in feelings and knowledge is then used to develop an action plan to be used in similar or comparable situations in the future. The aim of Gibbs's

model is to help learners link what has been learned from their reflection on a specific situation or experience to future experiences in the hopes that deeper knowledge may be constructed and that their competency in practice may increase.

Formative Assessment

The potential of FA for increasing knowledge and fostering lifelong learning is evident in the education literature (Cizek, 2010; Light, Cox, & Calkins, 2009; McWilliam & Botwinski, 2010; Wiliam, 2010), and an extensive number of definitions of FA can be found. For example, Boston (2002) offered a narrow definition when she suggested that situations where assessment information is used to align the teaching–learning process with the needs of students can be viewed as FA. In contrast, Popham (2008) suggested a broader view and defined FA as "a planned process in which assessment-elicited evidence of students' status is used by teachers to adjust their ongoing instructional procedures or by students to adjust their current learning tactics" (p. 6). Recognizing the dual role of FA, Popham alluded to the transformational power of FA for teaching and for learning. He simplified his definition by explaining that FA can be used to help "teachers to teach better and for learners to learn better" (p. 137). In this context, FA can therefore be viewed as a collaborative partnership between teachers and students for the following purposes: (a) to pinpoint students' knowledge gaps, (b) to ascertain the relevance and effectiveness of the teaching strategies used, and (c) to make necessary adjustments in the teaching–learning process in order to foster learning and enhance students' chances for academic success.

When referring to FA in their widely cited review of the literature, Black and Wiliam (1998) suggested that "it is to be interpreted as encompassing all those activities

undertaken by teachers, and/or by their students, which provide information to be used as feedback to modify the teaching and learning activities in which they are engaged" (p. 8). As they continued their work, Black and Wiliam's (1998) conceptualization of FA remained focussed on teaching and learning activities, and although they were praising the potential of FA to enhance learning, their definition was focussed on process. Their most recent work reflects emphasis on purpose, where they acknowledged that "it is clear that formative assessment is concerned with the creation of, and capitalization upon, 'moments of contingency' in instruction for the purpose of the regulation of learning processes" (Black & Wiliam, 2009, p. 10). Taras (2002) criticized writings by Black and Wiliam for presenting contrasting definitions of FA and for discounting the unique relationship between theory and practice. Notwithstanding, current literature on FA continues to refer to Black and Wiliam's extensive work as foundational to the advancement of FA (Ecclestone, 2010; Greenstein, 2010; Irons, 2008; Maki, 2004).

The dichotomy between assessments for learning versus evaluation for academic progression is a multifaceted challenge that is widely documented in the education and nursing literature (Cizek, 2010; DeYoung, 2009; McWilliam & Botwinski, 2010; O'Connor; 2001; Wiliam, 2010; Yorke, 2003). Wiliam and Black (1996) defined assessment as a dynamic cycle that includes the elucidation of evidence of student knowledge, the interpretation of the evidence collected, and the actions directed toward the enhancement of learning. They viewed the two functions of assessment, namely summative and formative, as extremes of a continuum and cautioned that using the terms formative and summative to describe assessment often leads to tensions, because there are times when assessment approaches, and the resulting outcomes, can be used both

formatively and summatively. Taras (2002) disagreed and claimed that both processes of SA and FA should be made explicit if the practice of assessment is to be understood and credible.

Allusion to a constructivist worldview is evident in much of the literature on FA (Black & Wiliam, 2009; McMillan, 2010; Young & Maxwell, 2007). The emphasis on active student engagement within FA is guided by the constructivist ideology, which views the student as an active participant in the construction of new knowledge. The literature on constructivism is extensive and complex. Noddings (1998) referred to constructivism as "a philosophy, an epistemology, a cognitive position, or a pedagogical orientation" (p. 115), while Airasian and Walsh (1997) defined constructivism as "a philosophical explanation about the nature of knowledge" (p. 444). Young and Maxwell (2007) referred to constructivism as an epistemology when they defined it as a "theoretical position" and a "descriptive theory of the process of learning" (p. 8). The fact that the literature presents multiple variants of constructivism adds complexity to the task of uncovering the theoretical underpinnings of the concept.

A considerable amount of literature written by contemporary supporters of the constructivist worldview endorse the tenets of Vygotsky's theory of knowledge construction and refer to it as social constructivism (Noddings, 1998; Packer & Goicoechea, 2000; Palincsar, 1998; Young & Maxwell, 2007). Contrary to the cognitive constructivist Jean Piaget, who concentrated his research on human interactions with objects, the focal point of Vygotsky's (1978) inquiry was the influence of social interactions on knowledge construction. Although he recognized the influential nature of human development, Vygotsky claimed that learning precedes development, and he

criticized Piaget for ignoring the influential impact of social contexts, language, and culture on cognitive development. Vygotsky maintained that the learners' state of development could be enhanced when they are confronted with new situations that are not relevant to their mental schemas, and he also claimed that new knowledge and schemas could be constructed through guidance from more knowledgeable mentors. Influenced by Marx and Engels, who believed that individual developmental changes originate from society and culture, Vygotsky believed that knowledge is constructed through interaction with the environment and that learning takes place in the zone of proximal development (ZPD). In defining the ZPD, Vygotsky stated, "it is the distance between the actual developmental level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance or in collaboration with more capable peers" (p. 86). He believed that students can construct a certain amount of knowledge individually; however, he claimed that assistance from peers or from a more knowledgeable person is required in order to develop or increase the students' knowledge base. In the context of this inquiry, FA was conceptualized as

> the collaborative processes engaged in by educators and students for the purpose of understanding the students' learning and conceptual organization, identification of strengths, diagnosis of weaknesses, areas for improvement, and as a source of information that teachers can use in instructional planning and students can use in deepening their understandings and improving their achievement. (Cizek, 2010, pp. 6–7)

Synopsis of the Literature Review

This integrative review of the literature provided a clearer understanding of FA as a process and as a teaching–learning strategy. It also substantiated the potential of FA to enhance learning and foster deeper meanings through the construction of new knowledge. Furthermore, it confirmed that an effective use of FA leads to readjustment in the processes of teaching and learning for students and teachers, which, in turn, could potentially result in enhanced knowledge. Although the concept of feedback was explored, a distinct definition was not found. For the purpose of this inquiry, feedback was defined as "information about the gap between the actual level and the reference level of a system parameter which is used to alter the gap in some way" (Ramaprasad, 1983, p. 4). The reason for choosing a definition that addresses the function of feedback rather than the nature of the information is based on Ramaprasad (1983), who claimed that the information given or received about a gap in knowledge can be considered feedback only when it is used to revise or adjust the gap.

The current nursing literature about the challenges facing nursing education as a result of the dynamic nature of the health care system is abundant. In this literature review, a snapshot of the nature of nursing education was presented including some details about the clinical performance assessment process of undergraduate nursing students. The teaching–learning strategy of guided reflection was discussed, and the cyclical reflection model developed by Gibbs (1988) was explained. Particulars associated with self-assessment in nursing education were introduced, and nursing students' perspective of the strategy was presented. The complex nature of CPA was portrayed, and problems associated with the process were introduced. One premise that

guided my motivation to focus this research on the use of FA in nursing education is rooted in the following statement by DeYoung (2009) about clinical experiences: "A certain amount of supervision must take place, but the emphasis should be on teaching and guiding, with the understanding that mistakes will be made" (p. 241).

While FA is presented as a teaching–learning strategy to enhance knowledge construction in the education literature, that particular pedagogical aim is not used to its full potential in nursing education. The fact that students' performance is assessed as soon as they enter the clinical setting and all of these assessment data are used to assign a clinical grade reinforces the view of clinical experiences as testing environments. The literature provides evidence that further research on issues surrounding the teaching and learning process in clinical nursing education is needed. However, the focus of this inquiry is limited to the experience of being assessed as a nursing student when FA is embedded in clinical courses. This research asked: How is the phenomenon of assessment experienced by nursing students when FA is formally embedded in clinical courses? It sought to uncover the phenomenon of assessment for nursing students who had lived the experience and to describe the meaning of that experience as they perceived it. This literature review guided the inquiry until data analysis was completed.

Further review of the literature was conducted to situate the textural and structural meanings embedded within co-researchers' experience. This additional literature is presented in Chapter Five to illuminate the phenomenon and discuss potential application of the study findings.

CHAPTER THREE: METHODOLOGY AND RESEARCH DESIGN

The intent of this research was to give voice to nursing students as they shared their experience with assessment in clinical courses. The research question guiding the study was: How is the phenomenon of assessment experienced by nursing students when FA is formally embedded in clinical courses? Because the purpose of the study was to explore lived experience, a qualitative research was conducted. In this chapter, the rationale for choosing the transcendental phenomenological human science approach developed by Moustakas (1994) is explained, and a description of the research design guiding this study is discussed. Details about the process of data analysis are presented using excerpts of co-researchers' stories.

Methodology

Streubert and Carpenter (2011) suggested that phenomenological research is the most appropriate method when the following two conditions are met: (a) there is a gap in the literature indicating the need for further clarity on the phenomenon of interest and (b) participants' lived experience is a rich source of data relevant to the phenomenon of interest. In this context, a significant gap in the literature on the use of FA in nursing education was identified and students who have experienced the phenomenon of assessment where FA was formally embedded in their clinical courses were accessible. Consequently, it was determined that a phenomenological study of the lived experience of nursing students with FA formally embedded in clinical courses would be an important contribution to the state of the knowledge on FA in clinical nursing education.

According to Denzin and Lincoln (2011) "qualitative inquiry seeks to discover and to describe in narrative reporting what particular people do in their everyday lives and what their actions mean to them" (p. 43). For Creswell (2013):

> Qualitative research begins with assumptions and the use of interpretive/theoretical frameworks that inform the study of research problems addressing the meaning individuals or groups ascribe to a social or human problem. To study this problem, qualitative researchers use an emerging qualitative approach to inquiry, the collection of data in a natural setting sensitive to the people and places under study, and data analysis that is both inductive and deductive and establishes patterns or themes. The final written report or presentation includes the voices of participants, the reflexivity of the researcher, a complex description and interpretation of the problem, and its contribution to the literature or a call for change. (p. 44)

As a qualitative methodology, phenomenology endeavours to achieve a deeper understanding of the nature or the meaning of everyday experience through retrospective investigation of lived experience (Creswell, 2013; Moustakas, 1994; van Manen, 1990). Referring to phenomenological investigation, Husserl (1907/1964) claimed that "the whole investigation is an *a priori* one" (p. 46) and aims to uncover and describe the essence of phenomena before they present themselves to consciousness. In an exercise aimed at helping readers develop a basic understanding of the technical vocabulary and concepts related to phenomenology, Cerbone (2006) explained that "your momentary experience includes more than what you momentarily see, more that is, than what you are currently seeing" (p. 4). In this short statement, he alluded to the fact that before

presenting themselves to consciousness, experiences have a rich and complex structure that can be explored in all its dimensions or "Horizons" (Husserl, 1913/1982, p. 52) through phenomenological investigation.

As a novice qualitative researcher, I understand that "research is an interactive process shaped by one's personal history, biography, gender, social class, race, and ethnicity and those of the people in the setting" (Denzin & Lincoln, 2011, p. 5). Consequently I recognize the importance of making one's epistemological, ontological, and axiological positions explicit at the beginning of the inquiry process (Denzin & Lincoln, 2011; Moustakas, 1994; Spiegelberg, 1982; Streubert & Carpenter, 2011; van Manen, 1990). My worldview, situated within the socioconstructivist paradigm, guides my belief that knowledge and meanings are constructed through human interactions with the social world and that there are as many realities as there are human beings. Believing that reality is socially constructed fuels my deep interest for human beings, for how they experience life, and the meanings that they attribute to various experiences. As explained by Berger and Luckmann (1966), "everyday life presents itself as a reality interpreted by men and subjectively meaningful to them as a coherent world" (p. 19). Recognizing that my interest lay in understanding the subjective experience of everyday life, it was deemed that a qualitative research methodology aimed at uncovering and describing the various dimensions of lived experience was required for this inquiry. Berger and Luckmann claimed, "the method we consider best suited to clarify the foundations of knowledge in everyday life is that of phenomenological analysis" (p. 20).

Because the purpose of this study was to uncover and describe the phenomenon of being assessed in clinical courses from the perspective of nursing students, a descriptive

phenomenological inquiry was conducted. Moustakas' (1994) approach to transcendental phenomenology is a descriptive methodology for understanding and describing the significance of practical activities of everyday life. Like other approaches to human science research, it focuses on the wholeness of experience and it aims to uncover and describe meanings and essences. Thus, this approach was chosen for its aim to explore accounts of experience on a textural and structural level in order to understand the experience of nursing students at its most personal level.

Using the "Modification of the Van Kaam Method of Analysis of Phenomenological Data" (Moustakas, 1994, p. 120), a better understanding was achieved of *what* the experience of assessment is like when FA is formally embedded in clinical courses and *how* it came to be. Through the research process, the experiences of co-researchers were reduced to textural and structural themes. Consequently, vivid and detailed explanations of the commonalities of the experience under study were developed, and they are presented later in this chapter to illustrate the process of data analysis.

Philosophical Underpinnings of Phenomenology

Phenomenology is viewed as a valuable method for the study of phenomena relevant to nursing education (Creswell, 2013; Moustakas, 1994; Streubert & Carpenter, 2011; van Manen, 1984, 2014); hence, the transcendental phenomenology approach developed by Moustakas (1994) was chosen to guide the research process of this inquiry. Because the transcendental and phenomenological approaches originate from the field of philosophy, an exploration of the philosophy literature was undertaken in order to situate this research. Scruton (2001) claimed that the term *phenomenology* was invented in the

18th century by the German mathematician, J. H. Lambert, to describe the science of appearances. However, many authors (e.g., Sokolowski, 2000; Spiegelberg, 1982; Streubert & Carpenter, 2011) have provided comprehensive overviews of the phenomenological movement and have identified Edmund Husserl as the originator. Dubbed the most influential philosopher in the advancement of phenomenology, Husserl was an ardent critique of the positivist philosophy, and he claimed that a phenomenological methodology would lead to "a return to the lived world, the world of experience, which as he (saw) it is the starting point of all science" (Sadala & Adorno, 2002, p. 283). Husserl's ideas continue to influence the field of philosophy today, and his writings remain the starting point of many emerging philosophers' work.

The concepts and ideas that evolved through the advancement of phenomenology represent the concerns and beliefs of philosophers as well as their aspirations to understand and describe human experience as it is lived. Although Sokolowski (2000) described the various movements of the phenomenological tradition as stages defined by the philosophers who were the most influential within those stages, Spiegelberg (1982) and Streubert and Carpenter (2011) referred to phases of the phenomenological movement as preparatory, German, and French.

According to Streubert and Carpenter (2011), the preparatory phase of the phenomenological movement was influenced by Franz Brentano (1838–1917) and Carl Stumpf (1848-1936). The primary focus of phenomenology at the time was to clarify the concept of intentionality. A central figure in the advancement of the phenomenological movement, Husserl (1907/1964) suggested that intentionality relates to the inherent connection we have with the world and that conscious awareness is what makes it

possible to learn about reality through lived experience. He claimed that every perception and every thought that constitutes one's consciousness has some kind of meaning or signification. Husserl believed that consciousness is always *consciousness-of-something* (Holstein & Gubrium, 2005; Moran, 2012; Sherratt, 2006; Spiegelberg, 1982); therefore, he claimed that phenomenology was an interpretive approach to life and that its practice could help uncover the "ultimate structures (essences) of consciousness" (Koch, 1995, p. 828).

Four guiding principles of Husserl's conceptualization of phenomenology were identified by Sherratt (2006): (a) a desire to uncover essences, (b) the belief that human beings have "a kind of pre-conceptual apprehending of phenomena" (p. 76), (c) "our intuitive apprehending happens within particular lifeworlds" (p. 76), and that (d) human beings have a natural connection with the world, a notion he called intentionality. Similarly, Heidegger believed that human beings have some kind of intuitive or preontological way of *being-in-the world* or *Dasein*, and that essences can be revealed through a phenomenological inquiry of preontological understandings (Sokolowski, 2000; Spiegelberg, 1982). van Kaam (1966) believed that through human science research such as phenomenological inquiry, the essence of lived experience or the "primary mode-of-being-in-the-world" (p. 25) could be uncovered and described. The role of the phenomenologist, for Sherratt (2006), is to "bring to ontological understanding that pre-ontological understanding that Dasein already possesses as part of its being" (p. 76). He acknowledged that this could be done through two main phenomenological approaches: descriptive or interpretive.

The purpose of interpretive phenomenology is to explore meanings of phenomena through hermeneutic analysis of written text derived from people's narratives of lived experience. This approach seeks to uncover the *whatness* of a specific phenomenon through a phenomenological analysis of the words used to explain one's perspective of a lived experience. The interpretive phenomenologist "goes beyond the data to account for the data in a complete and non-contradictory manner" (Maggs-Rapport, 2001, p. 380). On the other hand, from the premise that all experience holds within it essential meanings, descriptive phenomenology such as transcendental phenomenology aims to uncover the *howness* and describe the universal essence of specific phenomena where "whatever shows up is described exactly as it shows itself" (Maggs-Rapport, 2001, p. 380).

Husserl's influence continued into the German phase of the phenomenological movement, and he believed that phenomenology should become the basis or foundation for philosophy and science (Sokolowski, 2000; Spiegelberg, 1982; Streubert & Carpenter, 2011). Edmund Husserl (1857–1938) and Martin Heidegger (1889–1976) are considered the most influential leaders of the German phase of the phenomenological movement (Sokolowski, 2000; Spiegelberg, 1982; Streubert & Carpenter, 2011). Heidegger, a student of Husserl, is credited for taking Husserl's work, which stemmed from his background in mathematics and science, and directing it towards a more philosophical direction (Moustakas, 1994; Sokolowski, 2000; Spiegelberg, 1982; Streubert & Carpenter, 2011; van Manen, 2014). As noted by Sokolowski (2000), "Heidegger saw the philosophical possibilities in Husserl's discovery of intentionality and exploited them with a vengeance" (p. 217). Martin Heidegger (1927/1962), best

known for his work on *Being,* believed that human beings have the ability to ponder their own existence. He called the human way of being in the world: *Dasein* (McConnell-Henry, Chapman, & Francis, 2009). Whereas Husserl focused on the epistemological aspect of the lived experience or life-world (*lebenswelt*), Heidegger's focal point was the ontological aspect of Being or what it is that causes beings to be (Koch, 1995; Sokolowski, 2000; Spiegelberg, 1982; Streubert & Carpenter, 2011). Consequently, Husserl is credited with advancing the philosophy of transcendental phenomenology, while Heidegger contributed to the development of hermeneutic phenomenology.

The last phase of the phenomenological movement was influenced by three French philosophers; hence its reference as the French phase of the phenomenological movement (Sokolowski, 2000; Spiegelberg, 1982; Streubert & Carpenter, 2011). The philosophies and writings of Gabriel Marcel (1889-1973), Jean-Paul Sartre (1905–1980), and Maurice Merleau-Ponty (1908–1961) contributed to the advancement of phenomenology in the 20th century (Spiegelberg, 1982). Marcel was a playwright, musician, drama critic, and a philosopher who believed that human beings have a need for transcendence, which he called ontological exigencies (Treanor, 2010). Jean-Paul Sartre, regularly called the father of existentialist philosophy, believed that existence precedes essence and claimed that human beings can mould their reality through their actions in the world (Johnston, 2006). On the other hand, Merleau-Ponty believed that perception precedes knowledge and that by exploring human perceptions of experience, phenomena can be brought to light (Spiegelberg, 1982). He defined a phenomenon as "the layer of living experience through which other people and things are first given to us" (Merleau-Ponty, 1945/2002, p. 66) and believed that we interact with the world by

perceiving it and existing in it. He concentrated his work on the bodily dimensions of human experience, while Heidegger focused on the concept of being. The French phase of the phenomenological movement was influenced by existentialist ideologies that resulted in the refinement of the concepts of embodiment and being-in-the-world (Sokolowski, 2000; Spiegelberg, 1982; Streubert & Carpenter, 2011).

Merleau-Ponty (1945/2002) referred to language as a carrier used to express different meanings. He believed that through a careful analysis of language, lived experience could be uncovered. He wrote, "to name a thing is to tear away from its individual and unique characteristics to see it as representative of an essence or a category" (Merleau-Ponty, 1945/2002, p. 204). Stewart and Mickunas (1990) claimed that, without context, meaning from a single word cannot be accurately extracted. With this in mind, the transcendental phenomenology researcher seeks to gather extensive descriptions of the phenomenon from participants. Merleau-Ponty (1945/2002) believed that lived experiences are individual and contextual perceptions of the world and that all acts are founded on our initial awareness of some phenomenon. Likewise, Todres and Galvin (2008) viewed phenomenological research as an attempt to grasp the meanings of human experiences and to reveal their significance through written words. They recognized the challenge in finding words to convey the complexity, substance, and attributes of phenomena and claimed that fundamental meanings can be lost or missed if researchers strive to use words in their literal sense. They advocated for an "aesthetic phenomenology" (p. 370) where language is used to convey "embodied interpretations" (p. 370) that use language in a manner that it can "connect to people in a heartfelt way

and be complex enough to awaken not just a logical understanding but the sense of it as it lives" (Todres & Galvin, 2008, p. 570).

With this in mind, I wrote phenomenological descriptions that aimed to give voice to the experiences of nursing students in a way that respected their own language and perceptions. While remaining aware that I am sharing the participants' experiences with others who may or may not have had similar experiences, I wrote the descriptions in a way that the nature of nursing students' experience as they lived it and the inherent phenomenon embedded in their stories were preserved. The emerging findings add to the state of the knowledge of the phenomenon and address an important gap in the nursing education literature. I recognize that no one can actually experience another's experience, but through the use of transcendental phenomenology as the research methodology, the phenomenon of assessment was uncovered and brought to light.

Aimed at uncovering a universal description of the essential structures of a phenomenon by interpreting narrative descriptions of lived experience, Moustakas's approach developed in 1994 is transcendental in the sense that it is guided by the transcendental philosophy of Edmund Husserl, where the focus is on the subjectivity of an experience and the discovery of its essential structures as they present themselves to consciousness. Moustakas (1994) proposed modifications to two methods of data analysis; however, the method guiding my research was the modification of the van Kaam method, which is situated in the fields of humanistic and anthropological psychology. van Kaam (1966) believed that "anthropological psychology can be relevant to humanistic psychology insofar as its integrative comprehensive knowledge of the psychology of man can be used by the humanistic psychologist for the promotion of his

humanistic aims" (p. 373), and he claimed that his approach sought to "disclose and elucidate the phenomena of behavior as they manifest themselves in their perceived immediacy" (p. 15). Moustakas's modification of van Kaam's approach was chosen for its congruency with Husserl's philosophical assumptions and for its focus on uncovering and describing human experience.

Key Concepts and Processes of Phenomenology

In transcendental phenomenology, the term *co-researcher* is used to emphasize the collaborative nature of the relationship between researcher and participant. Through an atmosphere of trust and empathic presence, the phenomenological researcher engages fully with participants who become co-researchers as they share interest in illuminating the phenomenon. The terms co-researcher and participants are used interchangeably in this dissertation.

Epoche is both a concept and a process fundamental to phenomenology. For Husserl (1907/1964), *Epoche*, a term likened to the concept of bracketing, meant "suspending all beliefs characteristic of the *natural attitude,* the attitude of common sense and science" (p. xvii). He believed that by suspending one's beliefs, biases, theories, and assumptions, the phenomenological researcher can reach a state of openness that permits a fresh look at phenomena, free from preconceived ideas or judgment. In Moustakas's (1994) approach to transcendental phenomenology, *Epoche* is an important concept but, most important, it is a fundamental process where the researcher is instructed to "suspend everything that interferes with fresh vision" (p. 86) in order to uncover the essence of phenomena without "prejudices and unhealthy attachments that create false notions of truth and reality" (p. 90). Although it shares commonalities with other phenomenological

approaches, differences exist in the "launching" (Moustakas, 1994, p. 21) of a study from the transcendental phenomenological perspective as well as in the data generation and data analysis methods. For example, the hermeneutic phenomenological human science approach developed by van Manen (1997) encourages its users to use bracketing at the beginning of the research process. Conversely, in the transcendental phenomenological approach developed by Moustakas (1994), *Epoche* is practiced throughout the process of inquiry and permeates all of the research activities aimed at reaching a universal description of phenomena. In this sense, the transcendental phenomenologist remains committed to maintaining a neutral stance throughout the research process in order for the phenomenon to show itself within the narratives of people who have lived it. While Moustakas claimed that "Epoche is rarely perfectly achieved" (p. 90), he affirmed that a commitment to practicing Epoche as dictated by his approach heightens one's openness to the data and reduces external influences.

Intuition is a fundamental concept in transcendental phenomenology, and it lies at the heart of Husserl's philosophy. In the *Merriam Webster Online Dictionary* (2014), intuition is defined as "the power or faculty of attaining to direct knowledge or cognition without evident rational *thought* and inference." This ability to think without awareness or the direct knowing that seeps into our conscious awareness without the intervention of deliberate thinking was explained by Myers (2002): "Sometimes we intuitively 'feel' what we do not know we know" (p. 28). He identified the ability for direct knowledge or for immediate insight as a core principle of phenomenology. While the concept of intuition pervades Husserl's writings, his use of the term remains ambiguous. Thus, many authors have attempted to define his unique conceptualization of the word intuition

(Detmer, 2013; Moran, 2012; Sokolowski, 2000; Spiegelberg, 1982; van Manen, 2014; Zahavi, 2003). To understand Husserl's meaning of intuition, Spiegelberg (1982) considered his cultural heritage and explored the meaning of the German term *Anschauung* that translates to "looking at" (p. 104). He suggested that, in the German language, intuition refers to "a sense of an inspirational idea or an instinctive anticipation" (Spiegelberg, 1982, p. 105). Sokolowski (2000) offered an easier explanation of intuition when he claimed " intuition is not something mystical or magical; it is simply having a thing present to us as opposed to having it intended in its absence" (p. 34). Moustakas (1988, 1994) referred to intuition as a belief that comes immediately, without reasoning or argument. He suggested that while keeping beliefs and assumptions in the background of awareness through *Epoche,* researchers use intuition to gain a better understanding of participants' stories. He claimed:

> Thus, the beginning place for deriving knowledge are the intuitions of the pure ego; this means abstaining from the biases of prejudgments, being free of the everyday sense impressions, and being removed too from the distortions of imagination. Such a perspective is similar to the first process of Husserl's transcendental phenomenology - - the Epoche. What one knows through intuition of the transcendental ego can be regarded with absolute assurance. (Moustakas, 1988, p. 9)

No consensus was found on the precise nature or the scope of intuition as ability. Hence, considering the German translation of *Anschauung* and Sokolowski's (2000) definition, intuition is construed as the manner in which something is known or the direct perception of an object.

Another key concept of phenomenology directly related to intuition is that of *intentionality,* or the notion that human beings are connected to and inseparable from the world in which they live. As explained by Plager (1994),

> Living in an already meaningful world allows us to make sense of what we are doing, makes it possible to do the activities we are doing, and allows possibilities for activities we have not yet done. The other side of this familiarity is that we may lose sight of the understanding that is in our everyday activity. Certain aspects get covered over just because of their taken-for-granted nature. (p. 70)

Adams (2010) explained phenomenology as the reflective study of the prereflective of the immediate experience. This implies that phenomenology is the reflective study of how we experience the world before we have the opportunity to think about it, before subjectivity and objectivity come into play. The unconscious connection we have with the world was defined by Husserl (1907/1964) as intentionality. He believed that human beings were connected to the world in which they lived and were always conscious of something. Moustakas (1994) espoused Husserl's concept of intentionality and explained that "we are always intentionally conscious of something; our consciousness points to a direction and has meaning" (p. 59). To illustrate this concept, Scruton (2001) used the example of a ghost and explained,

> When I see as a ghost what is in fact a piece of fluttering cloth, then the intentional object of my seeing is a ghost, while the material object is a piece of cloth. The intentional object is that which is 'present to consciousness' and it may not correspond to any material reality. (p. 264)

Intentionality as understood in phenomenology cannot be associated with the meaning of common related terms such as *intention* or *intentional* because, in the phenomenological sense, a distinction must be made between the material and intentional object of a mental state (Crotty, 1996). Instead, it must be understood as the internal ability to be conscious of something before awareness comes into play. As explained by Merleau-Ponty (1945/2002), "the unity of the world, before being posited by knowledge in a specific act of identification, is 'lived' as ready-made or already there" (p. xix). Therefore, by gaining access to the space where intentionality occurred, the researcher is able to uncover the essence of a phenomenon before subjectivity emerged. In the previous example of the ghost, by Scruton (2001), it is evident that intentionality is not only related to the object itself but also how the person perceives the object. It implies an objective experience of the object as well as a subjective experience of the same object. This is where the concepts of *noema* and *noesis* become relevant to phenomenology.

In order to uncover phenomena, the phenomenologist must explore the lived experience at the point where it is experienced prereflectively, before awareness comes into play. To accomplish this, it is important to recognize that every intention has a *noema* and a *noesis* (Moustakas, 1994; Sokolowski, 2000; van Manen, 2014). According to Moustakas (1994), the *noema* can be construed as the *what* of an experience, "not the real object but the phenomenon, not the tree but the appearance of the tree" (p. 29), whereas *noesis* refers to the *how* or "the way in which the what is experienced" (p. 69). Consequently, because of the belief that "what appears in consciousness is an absolute reality while what appears in the world is a product of learning" (Moustakas, 1994, p. 27), to uncover the *noema* and the *noesis* of an experience through phenomenological

investigation is to uncover the what and the how of that experience. In other words, it is to identify and describe that experience as it is lived before subjectivity influenced co-researchers' consciousness.

The transcendental phenomenological method provided the philosophical underpinnings to guide this inquiry, and Moustakas's (1994) approach provided the framework for accessing, interpreting, and describing the phenomenon.

Research Design

For Moustakas (1994), transcendental phenomenological research is the exploration of human experience and it shares common bonds with other human science research models. He identified the common bonds as the following:

1. Recognizing the value of qualitative designs and methodologies, studies of human experiences that are not approachable through quantitative approaches.
2. Focusing on the wholeness of experience rather than solely on its objects or parts.
3. Searching for meanings and essences of experience rather than measurements and explanations.
4. Obtaining descriptions of experience through first-person accounts in informal and formal conversations and interviews.
5. Regarding the data of experience as imperative in understanding human behavior and as evidence for scientific investigations.
6. Formulating questions and problems that reflect interest, involvement, and personal commitment of the researcher.

7. Viewing experience and behavior as an integrated and inseparable relationship of subject and object and of parts and whole. (p. 21)

The transcendental phenomenological human science approach guiding this inquiry assigns great importance to *Epoche*. Recognizing that his approach is descriptive in nature, Moustakas noted that within his proposed methodology, reflection and intuiting cannot be done in isolation of the *Epoche* process. He argued that the transcendental phenomenologist must practice *Epoche* throughout the course of the research endeavour in order to remain "unfettered" (Moustakas, 1994, p. 85). In the context of this study, the phenomenon was the essence of the lived experience of nursing students with FA as shared during semistructured individual interviews. The transcendental phenomenological approach guided by Husserl's philosophy was the methodological foundation, and the modification of van Kaam's approach to phenomenology developed by Moustakas was used as the systematic process for data analysis.

Because words and the individual meanings attributed to them are central to this methodology, one definition was chosen to delineate the concept of FA and to guide this research. Therefore, as specified in the literature review section, FA was defined as

> the collaborative processes engaged in by educators and students for the purpose of understanding the students' learning and conceptual organization, identification of strengths, diagnosis of weaknesses, areas for improvement, and as a source of information that teachers can use in instructional planning and students can use in deepening their understandings and improving their achievement. (Cizek, 2010, pp. 6–7)

To adhere to the tenets of phenomenological inquiry, Bell and Cowie (1999) suggested that the background of the researcher needed to be clearly disclosed to ensure that readers are aware of the perspective with which the text was analyzed and written. The concept of bracketing was addressed by Husserl during the preparatory phase of the phenomenological movement where he conceptualized bracketing or *Epoche* as a way of suspending one's beliefs about the world and making them separate from oneself so that the person could concentrate on uncovering the essences of a phenomenon as it was lived by others (Koch, 1995). Sokolowski (2000) believed that bracketing is more than bringing one's values, beliefs, and knowledge about phenomena to the forefront. He suggested that it should be done so that the phenomenon can be contemplated "precisely as it is intended by an intentionality in the natural attitude" (Sokolowski, 2000, p. 49). Kant conceptualized phenomena as the appearances we grasp through our senses; therefore, if a phenomenon is a perceived entity, then it is contemplated from the point of view of a perception (Sokolowski, 2000). Similarly, if the phenomenon is an experience that the researcher previously had, then it must be viewed from the standpoint of that actual experience and brought to consciousness as such. As explained by Reynolds (2005), "the researcher attempts to achieve 'openness' by 'entering the world of the [participant] without expectations of what will be found'" (p. 25).

Because Moustakas (1994) acknowledged the necessity for the phenomenological researcher to conduct a kind of personal introspection or bracketing that leads to the identification of any beliefs, values, or knowledge of the phenomenon to be studied in order to bring them to consciousness, my experience as a former nursing student and as a current clinical instructor was clearly delineated from the beginning of this research. As

explained in Chapter One, my interpretations were acknowledged and "suspended" so full attention could be devoted to the phenomenon under study (Holstein & Gubrium, 2005). I believe that the interpretation of the phenomenon resulting from the activity of bracketing is only one description of the phenomenon; that is, my own. Having this brought to light and through the consistent practice of *Epoche*, I made every effort to pursue a value-free analysis of the narratives of participants that permitted the phenomenon to reveal itself as experienced (Holstein & Gubrium, 2005; Husserl, 1907/1964, 1913/1982; Moustakas, 1994). Furthermore, the question, "How is the phenomenon of assessment experienced by nursing students when formative assessment is formally embedded in clinical courses?" was kept in the forefront of all research activities related to this inquiry to ensure a focused exploration of the co-researchers' lived experience.

Selection of Site and Participants

The concept of purposeful sampling is fundamental to phenomenological inquiry (Creswell, 2013). Because only people who have lived a particular experience can share their perspective of that experience (Creswell, 2013; Moustakas, 1994; Sokolowski, 2000; Streubert & Carpenter, 2011; van Manen, 1997), participants for this study were nursing students who lived the experience of being assessed in clinical courses where FA was formally embedded. According to Hays and Singh (2012), "the intention in *purposive* sampling is to select participants for the amount of detail they can provide about a phenomenon, and not simply selecting participants to meet a certain sample size" (p. 8). In the context of this study, a purposive sampling method was used to recruit third year nursing students from a midsize Canadian university. The decision to recruit from

this particular population was based on the fact that, at that point in their nursing program, third year students had ample experience with FA in at least five clinical courses.

This study was conducted at a midsize Canadian university offering a multisites nursing curriculum. Students can study towards a Bachelor of Nursing degree at the main campus or at one of three additional sites in the province where the university is located. At the end of their nursing program, all students, including students from the distant sites, are granted a Baccalaureate degree in Nursing from the university.

For the purpose of this study, nursing students from the main campus and from one distant site were recruited. Participants were asked to volunteer in the study through an e-mail sent on April 2, 2013 by the office of the Dean of Undergraduate Programs to all third year nursing students enrolled at the chosen locations.

An important consideration associated with sampling in qualitative inquiry relates to the number of participants that should be recruited. As reminded by Creswell (2008), the aim of gathering data for qualitative research is to reach "the repetition of discovered information and confirmation of previously collected data" (p. 30); therefore, the number of participants recruited varies from one study to another. He claimed that because the purpose of qualitative research is not to generalize findings, "a few sites or individuals" (Creswell, 2013, p. 157) combined with extensive descriptions of the problem under study should be considered adequate for qualitative research. van Manen (1990) warned that "before embarking on a busy interview schedule one needs to be oriented to one's question or notion in such a strong manner that one does not get easily carried away with interviews that go everywhere and nowhere" (p. 67). Plager (1994) maintained that

redundancy in the merging themes and patterns provides confidence in the interpretation and determines the sample size. Duke (1984) suggested samples of three to 10 participants as adequate for a phenomenological study. For the purpose of this study, the minimum number of participants was set at six, and the actual number of participants was to be determined at the moment when the experiential descriptions shared during semistructured interviews were iterated and failed to offer new insight. Because only five participants volunteered to participate in the study following the first call for volunteers, third year coordinators at the chosen locations were asked to distribute a hard copy of the recruitment letter to all third year students at both sites on April 26, 2013.

Eight female nursing students volunteered to share their experience of assessment in clinical courses. All were Caucasian females between the ages of 20 and 35 years. Some of the co-researchers already had a previous university degree and were pursuing nursing as a second career. Half of the volunteers were students at the main campus, and the other four were studying at the distant site. Table 1 describes each co-researcher using her self-chosen pseudonym.

Instrumentation

The interview guide developed for the research proposal was piloted on April 3, 2013 with four third year volunteer students from a site other than where participants were to be recruited. Although the resulting feedback was used to refine some of the questions, they were kept broad so as to obtain rich and comprehensive descriptions of the lived experience where the phenomenon was inherent. The final interview guide (see Appendix B) was comprised of 10 semistructured questions aimed at getting narrative accounts of the lived experience of participants while providing room for flexible

Table 1

Participant Demographics

Pseudonym	Age group	School affiliation	Previous university degree
Miranda	25–30	Main campus	Yes
Holly	25–30	Main campus	Yes
Julia	20–25	Distant site	No
Rose	25–30	Main campus	No
Venita	25–30	Main campus	Yes
Ariel	30–35	Distant site	No
Erika	20–25	Distant site	No
Louise	30–35	Distant site	No

conversational interviewing.

Data Collection

Between May 2013 and August 2013, eight interviews were conducted. Because participants were given the opportunity to choose the location where they wished to be interviewed, four interviews took place at the main campus and the remaining interviews were conducted at two different locations chosen by participants. Each interview lasted between 50 and 80 minutes.

For van Manen (1997), conversational interviews are a means of gathering narrative descriptions of lived experiences and a vehicle to engage participants and the researcher into "conversational relations" (p. 66), which should lead to deeper exploration of the phenomenon under study. Moustakas (1994) suggested that the transcendental researcher create a climate of comfort and trust during interviews so as to enhance participants' disposition to provide comprehensive accounts of their lived experience.

For the purpose of this study, responsive interviewing was used to gather digitally recorded audiotaped narratives of co-researchers' perspectives on their lived experience of being assessed when FA was formally embedded in clinical courses. According to Rubin and Rubin (2012), "the researcher's ability to hear what is said and change direction to catch a wisp of insight, track down a new theme, or refocus the broader question is a core strength of the responsive interview" (p. 39). Because phenomenology aims to explore what it is like to live a particular experience, the responsive interviewing style allowed for flexibility and afforded me the opportunity to follow up on what participants shared in order to get richer descriptions of their experience. For Streubert

and Carpenter (2011), the phenomenological researcher is the instrument for data collection. After 31 years as a registered nurse and nursing instructor, I developed heightened listening skills that help me identify strategic information necessary to deliver individualized nursing care and to provide differentiated guidance to my students. Nevertheless, I remain a neophyte researcher and this is a new context for using my communication skills. Consequently, following a process of *Epoche*, I approached each interview as a novice researcher striving to gather data while staying close to the following question: How is the phenomenon of assessment experienced by nursing students when formative assessment is formally embedded in clinical courses? Throughout each interview, I maintained the focus of my inquiry on what it was like for nursing students to be assessed when FA was formally embedded in clinical courses. To complement the data-gathering process of audio recording, I made handwritten notes during and immediately after each interview in order to depict the nuances and particular characteristics of the interview that may not have been captured in the audiotapes.

In interpretive phenomenology, the researcher may be inclined to return to participants to confirm or substantiate initial findings; however, in descriptive phenomenology, "going back to subjects or using *judges* is not a legitimate validity strategy" (Maggs-Rapport, 2001, p. 380). Nevertheless, Moustakas (1994) suggested that a copy of the transcribed interview be sent to each participant for review and as an opportunity to share additional details of their experience if needed. Because the systematic approach proposed by Moustakas guided this study, the first draft of the interview transcripts were sent to each participant in June 2014.

As previously explained, one particularity associated with Moustakas's approach is that *Epoche* is to be conducted before each interview and during the interview, if necessary. Also, he suggested "often, the phenomenological interview begins with a social conversation or a brief meditative activity aimed at creating a relaxed and trusting atmosphere" (Moustakas, 1994, p. 114). In the context of this study, I performed the *Epoche* process before participants arrived for the interview, and relaxing music was played while they prepared for the interview. At the beginning and at the end of each interview, students were informed of the important value of their self-reports in advancing the state of the knowledge of assessment in nursing education.

Davidson (2009) pointed to the interpretive and representational qualities of transcribed data and noted that various kinds of transcription formats can be found in the literature. For the purpose of this research proposal, transcripts were considered "theoretical constructions" (Lapadat, 2000, p. 208); therefore, denaturalized transcription of the interview recordings was conducted. The denaturalized transcription process strives to include the characteristics of verbal language such as sighs, "ums," and "ahs" rather than following grammatical rules of punctuation (Davidson, 2009; Lapadat, 2000). According to Lapadat (2000), interpretation begins during the development of a study and continues throughout the phases of data collection, transcription, and analysis. She suggested that transcription is "an integral aspect in the qualitative analysis of language data" (Lapadat, 2000, p. 203) and that researchers who carry out transcription interact more closely with the data leading to familiarity with it early in the inquiry process. In the context of this inquiry, I transcribed verbatim all data gathered during audiotaped interviews and proceeded with analysis using Moustakas's (1994) approach to

transcendental phenomenological human science research. Tilley (2003) acknowledged the importance of data transcription and encouraged researchers to consider related issues early in the research process. She pointed to the importance of aligning the transcription process with the theoretical perspective of the research methodology used and in consideration of the methods employed to address study questions.

Transcribing the audiotaped interviews presented a greater challenge than anticipated, and the loss of a close family member during this gruelling task resulted in extending the transcription time to 8 months. More precisely, four interviews were transcribed between August and November 2013 and the remaining four were transcribed between April and May 2014. Hence, the reason for sending the transcripts for review in June 2014.

Data Analysis

The research process for this study began with the development of the research proposal and continued until the final writing of the phenomenological text identifying and describing the phenomenon of being assessed from the perspective of nursing students who have FA formally embedded in their clinical courses. The research approach developed by Moustakas (1994) entails that "organization of data begins when the primary researcher places the transcribed interviews before him or her and studies the material through the methods and procedures of phenomenal analysis" (p. 118). van Kaam (1959) maintained that although his methods for analyzing data are specified in a systematic framework, they "most often overlap and do not follow a fixed order" (p. 67). Nevertheless, due to the fact that I am a novice researcher and that I was using the transcendental phenomenological approach to human science for the first time, I closely

followed the systematic approach to data analysis as proposed by Moustakas and included in Appendix A. Also, Dr. Catherine Aquino Russell, a Parse scholar and expert in phenomenology, mentored me throughout my research activities as needed.

Because nursing curricula are constituted of both theory and practice courses, being a nursing student entails learning in different settings, such as classroom, clinical environments, and skills laboratories. Consequently, although this research focused on FA in clinical courses, participants included stories of learning in the classroom and in labs to expound on their individual experience with FA in clinical courses. Each interview generated 20–33 pages of transcribed data. Due to the large amount of data, and to enhance clarity and transparency for the reader, only examples of individual descriptions are used to illustrate the four processes of transcendental phenomenology: *Epoche, phenomenological reduction, imaginative variation, and synthesis* (Moustakas, 1988, 1994). Excerpts from Miranda's and Holly's descriptions are used as examples to explicate the various activities within the processes of phenomenological reduction and imaginative variation. To illustrate the activities of synthesis, descriptions from Julia and Rose are used as examples of individual textural-structural descriptions and quotes from Venita's, Ariel's, Erika's, and Louise's interviews are included in the composite textural-structural synthesis. While punctuation has been added to improve readability of the transcripts' portions presented, the distinct nature of individual linguistic style was preserved.

Wall, Glenn, Mitchinson, and Poole (2004) encouraged the use of a reflective diary to inform decisions during the research process. They also recommended a reflective framework for such a diary where (a) *prereflective preparation* can be used as a

space for planning and further bracketing, (b) *reflection* can be used to reflect on the research process as it unfolds, (c) *learning* can be used to bring new learning to the forefront, and (d) *action for learning* can be used to consider the new learning to date and how it can be used to adjust or uphold the research process. Similarly, van Manen (1997, 2002) recognized the value of journaling throughout the process of research and viewed it as a way to delineate research activities, to reflect on meanings and understandings stemming from reflective practice, and to document emerging insights. Recognizing the fact that I am a novice researcher and that I have never used the methodology of transcendental phenomenology, I used a research diary to track my reflective journey throughout the inquiry process.

Throughout the data collection and data analysis processes, all of the criteria included in the Research Ethics Board applications were followed diligently to ensure fair and equitable treatment of co-researchers and the data. Besides keeping my research diary private, confidentiality of participants' identity was assured through the use of self-chosen pseudonyms selected by participants before the interview process was initiated. Digital recordings, interview transcripts, and other related documentations related to this inquiry will be kept in a locked filing cabinet in my office for 7 years.

Transcendental phenomenology aims to interpret and describe the structure of lived experience through four important processes: *Epoche, phenomenological reduction, imaginative variation, and synthesis* (Moustakas, 1988, 1994). As the first process of transcendental phenomenology, *Epoche* aims to foster genuine looking at the phenomenon without preconceived biases. Reading about *Epoche* and practicing *Epoche* brought profound insight into the process. As a practitioner of QiGong, I easily transition

to a meditative state. However, *Epoche* required more than the ability to quiet my mind; it required a constant bracketing of my personal beliefs and experience so that I could openly, receptively, and mindfully attend to the participants' own personal experience.

According to Husserl (1907/1964), following an openness reached through *Epoche*, "we make the pure essence of perception give itself to our pure intuition" (p. xvii) through *phenomenological reduction.* Hence, in phenomenology, each lived experience is seen as a phenomenon unto itself and each description of the phenomenon is looked at as if for the first time, with a clear mind and free from preconceived notions. In the context of this inquiry, I not only practiced *Epoche* at the beginning of each steps of the research; every time I stepped away from the data, I did *Epoche* immediately before returning to the analysis and to the writing process.

Phenomenological Reduction

The second process of transcendental phenomenology, phenomenological reduction, helps describe in textural terms "just what one sees … the rhythm of the relationship between phenomena and self" (Moustakas, 1994, p. 90). The description that stems from phenomenological reduction includes what is stated and perceived including specific aspects of the experience, such as thoughts, feelings, and sounds. The process of phenomenological reduction includes various activities aimed at crafting individual and composite textural descriptions of co-researchers' experience.

Six steps constitute the process of phenomenological reduction: *bracketing*, *horizonalization*, *delimiting the invariant constituents of the horizons*, *clustering the horizons into themes*, organizing the horizons and themes into *individual textural descriptions of the phenomenon,* and developing a *composite textural description*

illuminating the textural meanings or *noema* and the invariant elements of the phenomenon.

After completing the interviews and transcriptions, I began the process of phenomenological reduction. Several measures were taken to ensure *credibility* in the analysis process. First, a piece of paper with the research question: "How is the phenomenon of assessment experienced by nursing students when FA is formally embedded in clinical courses?" was taped to my laptop monitor for the entire data analysis process, and it was used as an anchor to help me focus on the phenomenon under study. Furthermore, I used *Epoche* before each encounter with the data and during reflective analysis whenever I perceived a loss of focus.

Each step of the data analysis process developed by Moustakas (1994) took between 2 and 3 weeks and necessitated regular consultation with my methodology mentor to ensure adherence to the philosophical underpinnings of this particular approach. Guidance from the phenomenology expert focused exclusively on methodological issues. Only my supervisor and I accessed the raw data.

Moustakas (1994) proposed several specific activities to help researchers engage in phenomenological reduction, and he suggested that through those activities or processes, textural descriptions of phenomena emerge. The process of phenomenological reduction was conducted as follows.

Bracketing

Moustakas (1994) believed that following the process of *Epoche*, the researcher can look at the data with an openness that permits bracketing of the focus of the research, resulting in the elimination of data that are not relevant to the phenomenon being studied.

In this context, the first step of phenomenological reduction, bracketing, served to identify and keep the data that were relevant to the phenomenon. To achieve this type of bracketing, I read the transcripts one line at a time and highlighted statements that answered the research question. This process of reading and highlighting was repeated several times, and information that did not relate to the question guiding the study was eliminated. In this context, bracketing helped me attend to the focus of the analysis, and what remained were broad statements related to the phenomenon. Examples of bracketed statements extracted from the interview transcripts are presented in Table 2 and Table 3.

Horizonalization

As the second step of the phenomenological reduction process, horizonalization served to uncover the horizons embedded in the previously bracketed statements. Moustakas (1994) described this step as identifying "the grounding or condition of the phenomenon that gives it a distinctive character" (p. 95). In the context of this study, horizonalization was achieved through consideration of all statements previously identified as equally valuable and elimination of those that were deemed superfluous or unrelated to the phenomenon. Eventually, through consistent engagement with these data, further statements deemed irrelevant were eliminated, and the horizons of the phenomenon were identified. Hence, through repeated reading and reflecting, the broad bracketed statements were reduced to "horizons." Tables 2 and 3 illustrate the horizonalization process on portions of the interviews from Miranda and Holly.

As evidenced in Tables 2 and Table 3, the process of horizonalization resulted in the identification of what appeared unique and pertinent to the experiences shared by co-researchers. Further horizonalization is achieved when the invariant constituents of the

Table 2

Illustration of the Horizonalization Process: Miranda

Bracketed statements	Horizons
Lines 470–484: It makes me want to come back, it makes me be able to keep going and learning from my mistakes. And learning from other's mistakes, see things in a different way cause the formative would be me saying this is what happened, the instructor saying OK great reflection but what about this, what about this, what about this. So you want to go to clinical the next day and try those. OH yes, the oh yeah moments! I have more, of those moments than I do with summative, definitely cause you're talking with your clinical instructor, you're saying how you feel about something, you're reflecting, they're telling you way to go!, good job! Or, maybe you should think about it this way, and you're like: Oh, oh yeah, yeah. I guess you're having more of a communication, with your clinical instructor.	• Makes me want to come back. • Makes me able to keep going and learning from my mistakes and from others' mistakes. • See things in a different way. • You want to go to clinical the next day. • You're talking with your clinical instructor, you're saying how you feel about something, you're reflecting, they're telling you way to go!, good job! Or, maybe you should think about it this way.
Lines 557–577: You could lie in [name of written summative assessment]. Formative, the instructor was there with you and probably will remember this incident. You don't need to lie, you can be honest and truthful and not get docked marks, wow that's amazing! I already talked about being able and liberated to talk and not hesitant about what to say, what words to say, it's so liberating to a student. I don't want to stand there and think what should I say to you to pass? How should I say it, cause you're looking for something specific, I don't have time for that, I want to be a good nurse, I want to be on the floor, I want to experience from my mistakes, I want to figure it out go back on the floor keep going. Yeah.	• You could lie in [name of written summative assessment]. • Formative; the instructor was there with you and probably will remember this incident. You don't need to lie, you can be honest and truthful and not get docked marks, wow that's amazing! • I already talked about being able and liberated to talk and not hesitant about what to say, what words to say, it's so liberating to a student. • I don't have time for that, I want to be a good nurse, I want to be on the floor, I want to experience from my mistakes, I want to figure it out go back on the floor keep going

Table 3

Illustration of the Horizonalization Process: Holly

Bracketed statements	Horizons
Lines 180–211: With formative assessment, it really makes you feel more like you want to come to clinical, you want to learn. You're excited to try it the next time, and you're engaged I guess. Again, you are a participant in your learning where the other style, cause it makes you feel like hurry, more hesitant to learn to try next time because you think it's not, they won't approve of what you're doing I think you feel willing and I think it's more of a partnership like together you're working toward becoming a really good nurse. Whereas, if you are being told more or some more, I think aggressive micro managing style of teaching, then you just, it's like you back, you want to back off of learning, for me anyway. You just don't, you don't want to engage with that person, you just don't feel like they are receptive to your learning or something like that. I have a much more positive association and a more strong memories of things that really went well or unique to instructors that I remember in those clinical settings like very positively and they feel like I learned and retained more information from those settings than other. I don't want to think about what happened in a negative situation so not thinking about what I learned in those times as much as I would on a positive.	• With formative assessment, it really makes you feel like you want to come to clinical, you want to learn. You're excited to try it the next time, and you're engaged. You are a participant in your learning. • The other style, cause it makes you feel like hurry, more hesitant to learn to try next time because you think they won't approve of what you're doing • Aggressive micro managing style of teaching, you want to back off of learning. You just don't want to engage with that person, you just don't feel like they are receptive to your learning. • I have a much more positive association and a more strong memories of things that really went well or unique to instructors. I feel like I learned and retained more information from those settings than other. • I don't want to think about what happened in a negative situation so not thinking about what I learned in those times as much as I would on a positive.
Lines 231–234: Summative, you're always concerned about what you're doing, you don't just think and do. It's more like you get conscious of every move you're making everything and everything you're doing and I think part of nursing is to know what to do and doing it but you can't feel free to do that when someone is always watching over your shoulder assessing you and what you are doing.	• Summative, you're always concerned about what you're doing, you don't just think and do. • You get conscious of every move you're making and everything you're doing. • Part of nursing is to know what to do and doing it but you can't feel free to do that when someone is always watching over your shoulder assessing you and what you are doing.

(table continues)

Bracketed statements	Horizons
Lines 326–367: Some of them (instructors) just treat you like amazingly; they are very positive, they're very enthusiastic, they're very calm, cool and collected with whatever is going on. But other ones, it's just you're there to learn, your position is student you're not able to have, express your opinion or make a plan cause you're the student, your job is to listen to them and learn.	• Some of them (instructors) just treat you like amazingly; they are very positive, they're very enthusiastic; they're very calm, cool and collected with whatever is going on. • Other ones, it's just you're there to learn, your position is student you're not able to have, express your opinion or make a plan cause you're the student, your job is to listen to them and learn.

horizons are identified.

Delimiting the Invariant Constituents of the Horizons

Moustakas (1994) suggested that once the elements of consciousness embedded in the stories were bracketed into horizons, they should be delimited by removing "overlapping, repetitive and … vague expressions … terms." (p. 121). Throughout this third step of phenomenological reduction, I remained neutral towards the material and considered each statement as equally important, making sure not to attribute more significance to particular statements. All previously identified horizons were explored and statements that had little meaning or relevance to the experience were eliminated. The process of delimiting the invariant constituents of the horizons contributed to identifying the aspects of the experience that are basic to understanding it.

The examples included in Table 4 and Table 5 are the invariant constituents of the horizons that remained after delimiting was done to portions of Miranda's and Holly's data.

Thematic Clustering

The fourth step of phenomenological reduction is the clustering of the horizons into themes. In this process, after the horizons are delimited, they are clustered into thematic categories used to develop individual textural descriptions and one composite textural description. Boyatzis (1998) defined a theme as "a pattern found in the information that at minimum describes and organizes the possible observations and at maximum interprets aspects of the phenomenon" (p. 4). According to Creswell (2008), themes should have labels "of no more than two to four words" (p. 256). He suggested that "through initial data analyses, you may find 30 to 50 codes. In subsequent analyses,

Table 4

Illustration of the Process of Delimiting Invariant Constituents: Miranda

Bracketed statements	Horizons	Invariant constituents
Lines 470–484: It's makes me want to come back, it makes me be able to keep going and learning from my mistakes. And learning from other's mistakes, see things in a different way cause the formative would be me saying this is what happened, the instructor saying OK great reflection but what about this, what about this, what about this. So you want to go to clinical the next day and try those. OH yes, the oh yeah moments! I have more, of those moments than I do with summative, definitely cause you're talking with your clinical instructor, you're saying how you feel about something, you're reflecting, they're telling you way to go!, good job! Or, maybe you should think about it this way, and you're like: Oh, oh yeah, yeah. I guess you're having more of a communication, with your clinical instructor.	• Makes me want to come back. Makes me able to keep going and learn from my mistakes and from others' mistakes. • See things in a different way. • You want to go to clinical the next day. • You're talking with your clinical instructor, you're saying how you feel about something, you're reflecting, they're telling you way to go!, good job! Or, maybe you should think about it this way.	• Makes me want to come back. • Makes me be able to learn from my mistakes and from others' mistakes. • See things in a different way. • You want to go to clinical the next day. • Communication, with your clinical instructor. • Saying how you feel, reflecting.
Lines 557–564: You could lie in [name of written summative assessment]. Formative, the instructor was there with you and probably will remember this incident. You don't need to lie, you can be honest and truthful and not get docked marks, wow that's amazing!	• You could lie in [name of written summative assessment]. • Formative, the instructor was there with you and probably will remember this incident. You don't need to lie, you can be honest and truthful and not get docked marks, wow that's amazing!	• You could lie in [name of written summative assessment]. • Formative; you don't need to lie; you can be honest and truthful and not get docked marks, that's amazing!

(table continues)

Bracketed statements	**Horizons**	**Invariant constituents**
Lines 565–577: I already talked about being able and liberated to talk and not hesitant about what to say, what words to say, it's so liberating to a student. I don't want to stand there and think what should I say to you to pass? How should I say it, cause you're looking for something specific, I don't have time for that, I want to be a good nurse, I want to be on the floor, I want to experience from my mistakes, I want to figure it out go back on the floor keep going. Yeah.	• I already talked about being able and liberated to talk and not hesitant about what to say, what words to say, it's so liberating to a student. • I don't have time for that, I want to be a good nurse, I want to be on the floor, I want to experience from my mistakes, I want to figure it out go back on the floor keep going.	• Formative; liberated to talk and not hesitant about what to say. • It's liberating to a student. • I want to be a good nurse, experience from my mistakes, figure it out and keep going.

Table 5

Illustration of the Process of Delimiting Invariant Constituents: Holly

Bracketed statements	Horizons	Invariant constituents
Lines 180–211: With formative assessment, it really makes you feel more like you want to come to clinical, you want to learn. You're excited to try it the next time, and you're engaged I guess. Again, you are a participant in your learning where the other style, cause it makes you feel like hurry, more hesitant to learn to try next time because you think it's not, they won't approve of what you're doing. I think you feel willing and I think it's more of a partnership like together you're working toward becoming a really good nurse. Whereas, if you are being told more or some more, I think aggressive micro managing style of teaching, then you just, it's like you back, you want to back off of learning, for me anyway. You just don't, you don't want to engage with that person, you just don't feel like they are receptive to your learning or something like that. I have a much more positive association and a more strong memories of things that really went well or unique to instructors that I remember in those clinical settings like very positively and they feel like I learned and retained more information from those settings than other. I don't want to think about what happened in a negative situation so not thinking about what I learned in those times as much as I would on a positive.	• With formative assessment, it really makes you feel like you want to come to clinical, you want to learn. You're excited to try it the next time, and you're engaged. You are a participant in your learning. • The other style, cause it makes you feel like hurry, more hesitant to learn to try next time because you think they won't approve of what you're doing. • Aggressive micro managing style of teaching, you want to back off of learning. You just don't want to engage with that person, you just don't feel like they are receptive to your learning. • I have a much more positive association and a more strong memories of things that really went well or unique to instructors. I feel like I learned and retained more information from those settings than other. • I don't want to think about what happened in a negative situation so not thinking about what I learned in those times as much as I would on a positive.	• FA; you want to come to clinical, you want to learn. • You're engaged, a participant in your learning. • (in your face instructor); you feel more hesitant to learn because you think they won't approve. • Aggressive micro managing; you want to back off of learning, don't want to engage with that person, you don't feel like they are receptive to your learning. • More positive association and more strong memories of things that really went well or unique to instructors. • I learned and retained more information from those settings. • Don't want to think about what happened in a negative situation so not thinking about what I learned in those times.

(table continues)

Bracketed statements	Horizons	Invariant constituents
Lines 231–234: Summative, you're always concerned about what you're doing, you don't just think and do. It's more like you get conscious of every move you're making everything and everything you're doing and I think part of nursing is to know what to do and doing it but you can't feel free to do that when someone is always watching over your shoulder assessing you and what you are doing.	• Summative, you're always concerned about what you're doing , you don't just think and do. • You get conscious of every move you're making and everything you're doing. • Part of nursing is to know what to do and doing it but you can't feel free to do that when someone is always watching over your shoulder assessing you and what you are doing.	• Summative, always concerned about what you're doing. • Conscious of every move. • You can't feel free to know what to do and do it when someone is always watching over your shoulder assessing you.
Lines 326–367: Some of them (instructors) just treat you like amazingly; they are very positive, they're very enthusiastic, they're very calm, cool and collected with whatever is going on. But other ones, it's just you're there to learn, your position is student you're not able to have, express your opinion or make a plan cause you're the student, your job is to listen to them and learn.	• Some of them (instructors) just treat you like amazingly; they are very positive, they're very enthusiastic, they're very calm, cool and collected with whatever is going on. • Other ones, it's just you're there to learn, your position is student you're not able to have, express your opinion or make a plan cause you're the student, your job is to listen to them and learn.	• Some (instructors) treat you amazingly; they are positive, enthusiastic, and calm. • Other ones (instructors); you're the student, your job is to listen to them and learn.

you reduce these codes to five to seven major themes through the process of eliminating redundancies" (Creswell, 2008, pp. 256–257).

Initial Clustering of Horizons

Throughout repeated engagement with the delimited horizons, I identified themes that were relevant to each participant's narrative. The initial clustering of the horizons under thematic categories yielded 26 themes that were common to all participants' accounts: (a) learning hat; (b) long-term learning versus short-term; (c) guided reflections: embedded FA; (d) time constraints; (e) learning milestones; (f) FA is liberating/reduced fear to be judged; (g) doubt about true FA/ smoke and mirrors (summative); (h) reveals other perspectives; (i) less summative /more formative; (j) FA as confidence builder; (k) No grade/no marking; (l) contributes to learning/fosters Learning; (m) value of summative; (n) value of feedback; (o) shared learning/co-learning; (p) not learning from summative; (q) stress; (r) fosters engagement with current and future learning; (s) more of a communication with others; (t) power issue; (u) I want to be a good nurse; (v) instructor approach; (w) emotional and physical reaction to assessment; (x) FA as student–instructor partnership; (y) assessment: clinical vs classroom; (z) student knowledge of assessment strategies used.

After repeated review of the data and further thematic clustering, the 26 previously identified themes were integrated into six core textural themes that reflected the *noema* of the experience. Table 6 shows how the 26 textural themes were integrated into core categories. As indicated in Table 6, initially, the process of thematic clustering led to the identification of six textural themes. They were (a) Cognition and learning; (b) Guided reflection; (c) Impact of FA; (d) Impact of SA; (e) Stress; and (f) Instructor approach/

Table 6

Initial Textural Themes and Associated Horizons

Cognition and learning	**Guided reflection**	**Impact of FA**	**Impact of SA**	**Stress**	**Instructors approach/ power issue**
Learning hat	Embedded FA	Liberating: reduced fear of being judged	Doubt about true FA /smoke and mirrors	Less summative / more formative	Shared learning/ respectful mentorship
Long-term learning (vs. short-term)	Time constraints	Reveals other perspectives	Value of summative	Stress always present	More of a communication with others
Learning milestones	Value of feedback	FA as confidence builder	Not learning from summative	Student knowledge of assessment strategies used	Power issue
Clinical versus classroom	Fosters engagement with learning	No grade/ no marking		I want to be a good nurse	Instructor approach
		Contributes to foster learning		Emotional and physical reaction to assessment	Student–instructor partnership

power issue. Interestingly, as the clustering process unfolded, the data became clearer, and more defined textural themes subtly emerged with glaring relevance and clarity. The following excerpt from my research diary demonstrates my sense of amazement and glee once I realized that meanings were becoming clearer and more distinct as I continued to reflect:

> November 7, 2014
>
> Wow! This is unbelievable. I didn't see this before but now I understand what Husserl meant by "back to the things themselves!" The longer I look at these horizons, the clearer the themes are becoming. It almost feels like the data are speaking to me saying "look at me, I'm here, I was here all along!" This is such a special moment, this was so subtle, I am in awe!

Although I found the data analysis process to be a rigorous and time-consuming endeavour, experiencing moments where meanings embedded in the data became clear provided further motivation to continue to attend to the data and to strive to uncover the phenomenon embedded in the co-researchers' stories. The core textural and structural themes illuminating the phenomenon under study are presented in Chapter Four.

Textural Descriptions

The fifth step in the process of phenomenological reduction entailed "organizing the horizons and themes into a textural description of the phenomenon" (Moustakas, 1994, p. 97). Thus, I integrated the horizons identified through bracketing and horizonalization, as well as the themes identified through thematic clustering, into a textural description of the phenomenon for each participant. Through the activities of phenomenological reduction, the *what* or *noema* of the co-researchers' experience was

uncovered and descriptions of what it was like for students to be assessed when FA was formally embedded in clinical nursing courses were expounded. The process of developing textural descriptions was rewarding for me as a novice researcher, and the following excerpt from my research diary illustrates my reaction to completing the last revisions of the textural descriptions.

> November 27, 2014
>
> The process of looking at the data, reflecting and describing, looking at the data, reflecting and describing, looking at the data, reflecting and describing was repeated so many times! But now I see why it needed to be done. This is probably what Husserl and Moustakas alluded to when they said that through *Epoche* and repeated engagement with the data, you reach the space where intentionality occurs. This means that the 6 textural themes that have surfaced constitute the essence of what it was like for the students to live the experience of assessment in clinical courses. This has taken so much time, but it is so rewarding to get to this point!

Individual Textural Descriptions

The following are examples of the individual textural descriptions developed for Miranda and Holly.

Miranda. Miranda enjoyed learning in the clinical setting and, for her, the value of experiential learning far outweighed learning derived from written summative assessment. She explained, "That stuff that's tested and that is graded a, b, c, or d; that doesn't necessarily stay with me. It's the actual stuff on the floor that I experience, that is going to stay with me for the rest of my life." She valued the guided reflections

formally embedded as FA in clinical courses but wished that the required number of these specific assignments was greater so that students could get more feedback on their practice. "We are given two reflections to do per term and I think there should be more. You should be able to sit down and do more reflections, and get more feedback." Miranda recognized the impact of the student–instructor ratio in clinical settings as the reason for not having as much feedback as she would like: "There's no time. Clinical instructors, they have so many people to watch over and reflect with them. In spite of the many constraints associated with guided reflections, Miranda recognized that "the professors and clinical instructors have, in the amount of time that they do have, been able to show milestones."

In the context of FA, Miranda felt that "you get more feedback" and "they give another spin. You see things in a different way because the formative would be me saying this is what happened, the clinical instructor saying OK great reflection but what about this, what about this, what about this." Miranda also felt that "out of formative can come a teaching opportunity for the full clinical rotation as opposed to [name of summative assignment] which I'm not gonna learn from my classmates, learning from others' mistakes." Because of its potential to highlight different ways of doing things, Miranda viewed FA as a catalyst to foster student engagement in their learning; "you want to go to clinical the next day and try those." Miranda shared that personally, feedback from formative assessments "it makes me want to come back. It makes me be able to keep going and learning from my mistakes." She felt that formative assessment "shows strength and a person's abilities on the floor." Clinical experiences where FA was integrated led to *Aha! Moments* for Miranda, and she stated that

> I have more of those moments than I do with summative, definitely because you're talking with your clinical instructor, you're saying how you feel about something, you're reflecting, they're telling you, way to go!, good job! Or, maybe you should think about it this way, and you're like: Oh oh yah yah.

Miranda shared concerns over the fact that assignments that should be exclusively formative are sometimes integrated into summative assessment feedback; "the two reflections that we do will kind of leak into my [name of specific summative assignment] writings." She further explained,

> Sometimes, in my reflections, I think I am getting graded because it seems to reflect on my summative. When I do get formative, most of the time I'd say 90% of the time; it's like I'm telling you how I feel about this reflection or how I'm reflecting on this situation, it shouldn't be graded 'cause this is my opinion.

Referring to a specific summative assignment required in all clinical courses, Miranda noted, "it's for us to learn from but I'm not learning from them."

Miranda explained that she feels stressed when assessed summatively, "I've stressed myself out, I've lost sleep over having to write [name of specific summative assignment] because first of all every professor is different." She explained that with formative assessment, "it's less stress on student, less stress on the clinical instructor, that's an assumption." Miranda noted that in a formative assessment culture "you're having more of a communication with your clinical instructor, with your peers, with your patient."

To validate her perception of a power dynamic in clinical courses, Miranda shared a specific clinical experience:

> I've had a horrible experience in [specific name of a different program], because they had too much friggin' power so formative is less. Some power taken away from the instructor, given to the student and I think that's probably fair assessment.

As a result of this particular experience, Miranda felt that "formative gives the clinical instructor less power to fail someone" and that in "summative, well they have too much power." She added "formative is less power for the clinical instructor which I think is what is needed." Furthermore, Miranda felt that instructors "have way too much power right now cause some girls aren't going through where their clinical instructor does not like them, they did it with [specific name of different program]."

Miranda concluded by saying, "I want to be a good nurse. I want to experience from my mistakes, I want to figure it out, go back on the floor, keep going." She praised one instructor's approach and her consistent use of FA as pivotal to her professional aspirations "I was able to feel more confident to pursue my goal."

Holly. Holly conceptualized FA as reflective work, both written and verbal, that is focused on the student's perspective of his/her own practice combined with written and verbal feedback received from instructor. She acknowledged the positive influence of FA on learning but found that she learned less from SA as she explained:

> The guided reflection that's more formative and I guess it can carry on, you reflect on it. The [name of specific summative assignment], it's just feel like something you've done to get it done and it's not something I would necessarily look back on.

She admitted that in SA situations "it seems like you're just grasping at straws sometimes to pass." On the other hand, Holly found formative assessment "much more fulfilling" and viewed it as a strategy that brings on "a different perspective that you didn't think of before." Holly shared that in formative assessment "you can actually talk about what's bothering you and what you need to work on or something like that without worrying oh my gosh am gonna pass or fail?" Furthermore, Holly indicated that with formative assessment, "you are a participant in your learning" and the feedback she received made her "confident to face whatever challenges come up in the day." Referring to an experience with FA in clinical, Holly shared "I was glad to know that overall it was OK but I should work on this because I like to know what I need to do to be better." She felt that with FA, "you're excited to try it the next time, and you're engaged I guess."

Holly construed a clear divide between learning derived from FA and learning constructed from SA; "The way I see it is the holistic versus skill oriented." She explained,

> I think the learning in more formative situations is kind of almost more holistic in a way, you learn how the whole situation works. In a more summative (situation), learning is skills focused. Ok I got this done, I know how to do this.

As a result, Holly viewed SA as "minimally useful" and merely as an academic requirement. Referring to the main summative assignment of her clinical courses, Holly stated, "it's just feels like something you've done to get it done and it's not something I would necessarily look back on." Holly also described SA as an obligation.

> Summatively, it feels like a cloud on your shoulder, someone's watching you. You need to perform this so you can get it done and so it just doesn't feel like enjoyable learning. It just feels like learning because I have to learn it.

She further explained that "part of nursing is to know what to do and doing it but you can't feel free to do that when someone is always watching over your shoulder, assessing you and what you are doing." Overall, Holly found SA more stressful than FA and stated "in the opposite side of things, summative, you're always concerned about what you're doing, you don't just think and do. It's more like you get conscious of every move you're making and everything you're doing."

Referring to a particular SA where she perceived a personality conflict between the instructor and her, Holly shared:

> It felt terrible. Yeah it's really visceral, it caused me to be very on edge. I didn't really have much of an appetite so, I mean other people are less sensitive than me to feedback but for me it was like a very physical reaction.

When asked to describe her physical reaction to FA, Holly answered: "I think it's still a lot more relaxed, more calm and just kind of more at ease and prepared."

Holly valued co-learning and described the contribution of others to her learning. Talking about her perception of a student–instructor relationship within a FA culture, Holly stated, "I think it looks a lot more like collaborative learning, it's like you're holding hands, you could learn together, it's more inclusive and just feels better, feels happier learning." She further elaborated on the supportive nature of a student–instructor relationship where FA is used by saying "it can reassure yourself. Ok I was right to think

this or yeah I need to do, need to improve on that and my instructor supports me in this or agrees with that."

Holly found the approach taken by instructors and nurses in the clinical setting as critically influential on student learning.

> You have to account for not only your instructor, but your primary and the other nurses on the floor because, there are some primaries, they're awesome and they'll help me if I need it. And there's other ones that put fear or dread into your body because they're not helpful. They don't want you there. They're just not willing to be a part of your learning or realize that if they took 5 minutes to teach you this one thing, that you could do it and that they wouldn't have to do that anymore, that you could help them out.

Unfortunately, because Holly experienced situations where some nurses were not a positive influence on her learning, she developed the following belief:

> The unfortunate side of healthcare, there is always some sort of a power structure. The thing we always hear when we enter nursing school is "Nurses eat their young." It doesn't have to be like that. It's the mindset that has been there.

Nevertheless, Holly recognized nurses' valuable contribution to student learning

> Your primary in some situations is more influential or sees you do more things than your instructor because the instructor has to chase after six or seven people and at this stage of the game we get at least two patients each so they can't have that time to teach you necessarily.

Holly remained hopeful that things could improve in the future with the integration of more FA in clinical nursing education. "I think moving towards more

positive attitudes and assessments right from nursing school; then that's the kind of nurse you bring up, that's the kind of nurse that will exist." Holly noted that

> the way this generation of nurses that is in the workplace now … you can really see a difference between the ones that are more team oriented, they are more helpful and can be of some assistance to you and the older ones are very set in their ways, they don't want to help out and I think crusty.

Holly described her perception of power dynamics between instructors and students as dependent on the approach to teaching taken by clinical instructors. To clarify her position, Holly compared some instructors as *helpful* and others as *in your face;* "some of them just treat you like amazingly ok let's learn this, let's do this, you're gonna be a great nurse. They are very positive, they're very enthusiastic, they're very calm, cool, and collected with whatever is going on." She added,

> You feel more empowered too if you hear "good that was very good what you could have done better or you could have done this better" than just hearing negativity. It really makes you feel more like you want to come to clinical, you want to learn.

Holly further explained, "but other ones, it's just, you're there to learn, your position is student you're not able to express your opinion or make a plan cause you're the student and your job is to listen to them and learn."

Holly felt that instructor approach and power issues have a critical influence on student learning.

> I have a much more positive association and a more strong memories of things that really went well or unique to instructors that I remember in those clinical

> settings like very positively. I learned and retained more information from those settings than others. I don't want to think about what happened in a negative situation so I'm not thinking about what I learned in those times as much as I would on a positive.

Holly found that her learning was influenced negatively by instructors that she identified as "*in your face*" and she explained "the other style, it makes you feel like hurry, more hesitant to learn to try next time because you think it's not, they won't approve of what you're doing." She added,

> If you are being told, I think, aggressive micro managing style of teaching, then you just, you want to back off of learning. For me anyway. You just don't, you don't want to engage with that person, you just don't feel like they are receptive to your learning.

Holly shared an experience when she perceived a personality conflict with a particular instructor. "I didn't feel like I could ask her about anything. I didn't want to ask her because she was intimidating to me at that time and so it didn't feel comfortable to learn." Following a particularly stressful event, Holly confessed,

> I felt like really stressed out about this because if this person is in my face and I felt like OK is she not gonna pass me or is she gonna write something that's gonna reflect badly on my clinical assessment when it's not actually, it's not something in my mind that should have a been major issue.

Holly noted that she felt lasting effects of her negative experience "that day well and probably the next couple of days until I felt it resolved, it just felt very, it wasn't learning

it was just doing like following by the book." She admitted to having a sense of potential doom as she explained:

> The first thing that I thought was just, ok well, how is this going to affect my future and my career or am I gonna even have to rearrange a few clinical days this summer. Oh my gosh my entire future like everything is gonna be ruined by this one person's particular mesh with me?

Admitting to feelings of powerlessness and disappointment related to this situation, Holly explained, "I'd never felt really powerless before, I couldn't say my side of the story or feel supported but that's kind of how I felt at that point. It just felt very disappointing." Further reflection on this particular event brought Holly to conclude "it's a student and instructor couple. That's the way it came up for me. I just like I couldn't defend myself I guess. There is no one I could go for support other than my peers."

When summarizing her conception of an effective student–instructor relationship, Holly explained, "you're making your own learning. I think it's more of a partnership like together you're working toward becoming a really good nurse."

Composite Textural Description

The sixth and final step of the process of phenomenological reduction is the development of a composite textural description. The following description constitutes the integration of each of the participants' individual textural description into a composite textural description of what it was like for students to experience assessment where FA was formally embedded in clinical nursing courses.

References to cognitive activity were fundamental to co-researchers' experience of assessment and framed their personal conceptualization of cognition and learning. For

some, the brain was perceived as a machine-like entity where knowledge could be constructed, forgotten, brought forth to awareness, or stored for future use. Co-researchers used metaphors such as *stove*, *door*, and *light* to explain their understanding of cognitive processes associated with learning in clinical courses. Viewing the brain as a stove implied that knowledge could be located on the front or back burner depending on the learning conditions at play. The concept of the front burner was directly related to consciousness or the student's focus of awareness during a learning event, while the concept of the back burner implied the presence of a space in the brain where learning was stowed or stored for safekeeping until needed. Many participants referred to knowledge remaining on the back burner or in the back of one's brain when anxiety was present. At such times, they believed that anxiety amplified by SA or their perceived fear of failing the course took the center stage of their consciousness and became the dominant focus of their learning experience. During those anxiety-filled times, participants admitted to having difficulty retrieving the knowledge that they needed to perform a skill or to answer questions. Consequently, they suggested that clinical performance and learning were negatively impacted by anxiety and fear of failing clinical courses.

Similarly, the brain as a storage space implied an area in the brain where knowledge is kept for indeterminate periods but accessible for retrieval if needed. Thus, co-researchers believed that knowledge remained stored until they were faced with specific learning situations, at which time the related knowledge moved forth to awareness so it could be used as required. The concepts of doors and lights were shared by one co-researcher who viewed her progress in the nursing program as a journey

through dark and shadowy spaces. She compared knowledge construction to the process of opening doors and turning lights on as she progressed through upper years and gained clinical experience.

In the nursing program where the co-researchers were enrolled, students were expected to complete two narrative guided reflections that are formally embedded as FA. Co-researchers deplored the fact that these particular assignments had to be done in written format. Their main criticism revolved around the time-consuming aspect of writing, because it was interpreted as a waste of their time. This was further explained by several admissions to spending more time writing assignments that were graded than assignments that did not count towards final grades. Nevertheless, they recognized the valuable benefits of the guided reflections and they identified feedback as the critical factor in learning.

The formative nature of guided reflections and the associated feedback on nursing practice were key factors in the co-researchers' learning, and it ultimately shaped their experience of assessment. They believed that formative feedback fostered learning by keeping them advised of their strengths and areas of needed improvement. References to the value of feedback were common as demonstrated in statements such as the following:

1. "Taking that feedback with me it's just a learning experience, I like knowing what I do right but I also like knowing what the heck I did wrong" (Ariel).
2. "The first time is always the most nerve racking but after you receive feedback and you kind of have a feel for it, then you gain confidence I guess. And you feel comfortable enough to do it again" (Miranda).

3. "It benefits me mentally for my self-esteem, it benefits my learning, realizing that I can do this, it benefits me. It benefits the patient umm they're confident in your skills, they see you happy" (Erika).

When lack of feedback resulted in students' perceived ignorance about their progress in clinical courses, they likened it to "being in the dark."

The potential for learning within a culture of FA was overwhelmingly acknowledged by all co-researchers, who expressed higher levels of engagement in their learning when aware that they were not being graded on their clinical performance. They believed that FA provided a relaxed environment where deeper knowledge was constructed and integrated into their practice of nursing. Hence, all co-researchers claimed that FA was more conducive to learning than SA. The fact that FA provided students with calmer environments and favoured learning resulted in their ability to see other ways of being and doing. Consequently, students who learned from FA situations were more open to other perspectives and shared being comfortable with trying different approaches used by instructors and other mentors.

SA was a significant element of each participant's story, and it was viewed in a predominantly negative light. Attributes that co-researchers associated with SA implied that it created an invisible imaginary wall that hindered their learning. Feeling responsible for patient safety and wanting to successfully pass their clinical courses, co-researchers experienced pervasive levels of anxiety whenever they were in the clinical setting. Although most admitted that their level of the anxiety intensified significantly when they perceived that they were being assessed under SA conditions, they acknowledged that a subtle state of anxiety was acceptable because they believed that it

prompted them to be more attentive as they practiced. Because of its perceived stress-producing effect, SA was loathed, as it triggered troublesome physical and psychological symptoms for all. Consequently, the co-researchers believed that under SA conditions, their cognitive processes were impaired, their performance was negatively impacted, and their learning was hindered.

Co-researchers used graphic metaphors to describe their experience with instructors in clinical courses. Symbols such as crutch, security blanket, guide, partner, couple, and metaphors, such as a mother hen and her ducklings and mamma bear and her cubs, were used to illustrate the distinctive nature of learning within clinical nursing courses. All of the co-researchers recognized the facilitating role of clinical instructors and they believed that FA provided ideal conditions for learning from and with others. Besides instructors, the co-researchers' peers, staff nurses, and patients were viewed as key contributors to student learning. Thus, all were considered co-learners.

The nature of the relationship between nursing students and clinical instructors was viewed as critical to the experience of assessment and to the process of learning to become a nurse. Although important, the level of nursing expertise that clinical instructors had was viewed as less influential than their approach to the SOTL. Participants believed that learning was enhanced and that their clinical practice significantly improved when clinical instructors consistently used FA and fostered a climate of mutual respect during clinical performance. They favoured FA to SA, because they believed that it fostered safe student practice and safe patient care. Evidence that FA fostered critical thinking, flexibility in practice, and adaptability to change was prevalent in all of the co-researchers' descriptions of their experience with assessment. Overall,

co-researchers wished for a pervasive use of FA in clinical courses, because they believed that it would contribute to future nursing graduates being competent nurses who possess the ability to adapt to the ever-changing nature of clinical environments.

Imaginative Variation

The third process specific to transcendental phenomenology is *imaginative variation*. With this process, the researcher seeks to uncover "possible meanings through the utilization of imagination, varying the frames of reference employing polarities and reversals, and approaching the phenomenon from divergent perspectives, different positions, roles, or functions" (Moustakas, 1994, pp. 97–98). Through this process, the essential structures of a phenomenon are revealed and, as explained by Moustakas (1994), "the *how* that speaks to conditions that illuminate the *what* of experience" (p. 98) are described. Through reflection, writing, and rewriting, possible meanings are uncovered and deep knowing about the experience emerges (Moustakas, 1988, 1994). Hence, imaginative variation results in individual and composite structural descriptions that explain *how* the phenomenon came to be for the co-researchers.

During the process of imaginative variation, I maintained mindful engagement with the textural meanings illuminated during phenomenological reduction and aimed to uncover possible structural meanings that could be embedded in the stories shared by co-researchers. According to Patton (2015), "the phenomenological attitude keeps us reflectively attentive to the ways human beings live through experiences in the immediacy of the present that is only recoverable as an elusive past" (p. 115). In this context, I consistently practiced *Epoche* and maintained a phenomenological attitude as I conducted imaginative variation by looking at the textural descriptions and considering

various possible structural meanings that lay within the data. This process aimed to uncover the how or *noesis* of the phenomenon. Like the process of phenomenological reduction, the process of imaginative variation required much time and constant engagement with the data. The textural descriptions were reviewed line by line for common structural themes. Although I was familiar with the concept of "being immersed in the data," I never understood the depth of its meaning until the structures of the experience of co-researchers revealed themselves as I explored the data from different stances and with different lenses. I was astonished at how, through iterative imaginative variation, the structural constituents of the phenomenon revealed themselves within the data and the textural themes became more distinct. The following excerpt from my research diary illustrates my reaction to uncovering the structural themes from the data:

> December 18, 2014
>
> This is taking a lot more time than I ever imagined! But it is getting easier, all of the themes are becoming more defined! Today, once the structural themes were identified, I really understood "how" the students perceived their experience of assessment in clinical. Those themes are the structural characteristic of the experience, the how, the *noesis*, the structures of the phenomenon.

Individual Structural Descriptions

Once the structures of the phenomenon are identified through imaginative variation, the researcher is expected to develop individual structural descriptions of the meanings and essences uncovered from the stories of co-researchers. The individual structural descriptions based on the universal structures identified illustrated *how* the participants experienced assessment when FA was formally embedded in clinical nursing

courses. The following examples present the structural descriptions of the experience developed for Miranda and Holly.

Miranda. Having experienced both summative and formative assessments throughout her nursing program, Miranda noted that she quickly forgot content that was learned to meet requirements of SA. On the other hand, she believed that knowledge constructed during clinical experiences that were assessed formatively became part of her permanent knowledge base. According to Miranda, learning experiences in the clinical setting resulted in deeper learning being stored in her memory for future access. The structures that encompassed Miranda's experience of FA in clinical courses were expressed in her desire for more time to discuss her own performance with instructors; her awareness that when used effectively, FA fostered freedom to share personal thoughts and feelings; and her belief that summative assessment may foster dishonesty in students when the fear of failing in present. Finally, Miranda's concern about a potential power differential fuelled by the type of assessment strategies used in the clinical setting was a significant structure influencing her experience of formative assessment.

Miranda liked the feedback derived from guided reflections but wanted more confirmation from instructors that her practice was adequate, so she wished for an increased number of required guided reflections in clinical courses. She hoped that extra time could be spent individually with her instructors to discuss guided reflections so they could focus on her own learning and nursing practice. Miranda showed discontent with the amount of time available to instructors resulting from the student–instructor ratio and felt that feedback on guided reflections was given hastily due to time constraints. Miranda referred to formative feedback on guided reflections as being given "on the fly,"

alluding to the harried manner in which most student–instructor meetings took place. The metaphor of "on the fly" was explained as a "hit or miss" kind of event where Miranda sometimes got the feedback she needed and at times remained in the dark about her own performance.

Because she believed that guided reflections were not graded, she assumed that she could be honest and truthful about her thoughts and feelings without the fear of being judged for the purpose of grading. She admitted that in the context of FA, she felt safe to freely talk about her own thoughts and feelings and even viewed FA as liberating. Miranda believed that FA fostered free and open sharing of students' personal emotions regarding their nursing practice; therefore, she wished for more formative assessment and less summative assessment in clinical courses. Miranda appreciated the enlightening quality of FA, as she felt that it helped uncover different perspectives and various ways of doing things. Miranda also felt that FA enhanced the teaching–learning environment by contributing to student engagement and respectful mentorship. Conversely, Miranda viewed summative assessment as exclusively focused on evaluating individual students' performance and grading without influence on knowledge construction or learning.

Miranda's preference of FA as an assessment strategy was better understood once her view of SA was deconstructed. Consequently, it became evident that for her, SA and especially the written summative assignments required in all clinical courses were not a true account of students' reflective practice. She explained that this type of SA does not consistently provide an accurate picture of one's knowledge or abilities because, as she stated, "some students are afraid to share their true feelings about clinical situations for fear of being evaluated." Interestingly, Miranda viewed written summative assessment in

clinical courses as "smoke and mirrors," and she believed that students who had good writing skills could be assured a good grade in clinical courses. Conversely, she believed that students who had less than adequate writing skills were aware of this disadvantage and compensated by embellishing their written reflections, rendering them scholarly satisfactory but inaccurately representing their knowledge and abilities. Miranda further disclosed that, on occasions, although guided reflections were supposed to be exclusively formative in nature, some instructors used them to enhance and support their summative feedback. She added that this practice made students wary of being open and honest in guided reflections. Having experienced it herself, Miranda stated that her formative assignments sometimes "leaked" into instructors' summative assessments, and it made her feel like she was being evaluated based on some things that she shared in her formative guided reflections.

Miranda's conception of SA was further guided by her belief that it contributed to increase the power differential already present in the student–instructor relationship. On the other hand, she believed that FA contributed to shared power and less subjectivity in the assessment process. Miranda had professional aspirations to become a registered nurse, and she believed that her goal could be attained in a culture of assessment where FA is used consistently and effectively.

Holly. The dominant structures underlying Holly's experience of FA in clinical courses were linked to her sense of engagement with learning when in FA contexts and to the perceived notion of obligation she associated with SA. Consequently, Holly experienced distinct physical reactions to both assessment strategies.

Holly viewed cooperation and sharing as germane to FA situations. Her relationship to others, especially instructors, was influenced by her perception of a power differential fuelled by instructors' approach to the teaching–learning process.

Holly expressed a sense of active involvement in learning during FA situations. She believed that under FA conditions, she constructed deeper knowledge from sharing her thoughts and feelings about her clinical experiences and then getting feedback from her instructors. For Holly, SA created stress and was merely an academic requirement that resulted in a sense of obligation to complete assignments and to perform tasks for the sole purpose of getting a grade. She viewed learning derived from FA as "holistic" and focused on deeper integration of the content to be learned. On the other hand, Holly referred to learning constructed during SA situations as more mechanistic, "skills oriented," and mainly focused on the general nature of the content to be learned.

The distinct nature of Holly's physical reactions to assessment shed a significant light on the profound impact that assessment can have on students. Hence, because she felt stressed during SA circumstances, Holly experienced negative physical reactions that ranged from gastric disturbance to lingering emotional distress. On the other hand, when reflecting on past FA instances, Holly shared feeling relaxed and prepared to practice nursing without the presence of physical symptoms.

In relation to others, Holly recognized the significant value of co-learning and the potential impact that a collaborative student–instructor relationship can have on students. She also praised the important contribution that nurses and others members of the health care team can have on student learning. Unfortunately, because she experienced situations where nurses chose not to welcome students to their units, Holly felt saddened

by the lost learning opportunities for both students and nurses that these situations triggered. Holly hoped that a more pervasive integration of FA in nursing schools could lead to future nurses being more aware of their impact on student learning and, consequently, be more open to welcoming and teaching students in their areas of practice.

Holly identified personality differences and approach to students as key factors in any student–instructor encounters. She felt that she learned more and better retained the knowledge constructed within relationships guided by mutual respect and collaboration. On the other hand, after experiencing a situation where she viewed the instructor as hostile and "in your face," Holly admitted that she did not respond well to such situations and that her learning was therefore stifled and superficial. Because she perceived an unbalanced amount of power in situations when instructors were "in your face," Holly worried that they could be inclined to subjectively use their position of power to influence their assessments. She shared that she once feared failing a clinical course when a personality conflict between her and a particular instructor was perceived. Holly's conception of the ideal student–instructor relationship was summarized as a partnership geared at fulfilling her professional aspiration of becoming a "really good nurse."

Composite Structural Description

The last step of the process of imaginative variation is to develop a composite structural description of the experience. Analysis of the data shared by co-researchers revealed several universal structural themes that uncovered the noesis or the "how" of their experience of assessment in clinical courses; these themes are presented in Chapter Four. The following description constitutes the integration of each participant's

individual structural description into a composite structural description of *how* they, the co-researchers, experienced assessment in clinical courses where FA was formally embedded.

Participants shared distinct perceptions of how learning occurred in their brain. The conceptualization of the brain as a mechanical device was prevalent, and the co-researchers believed that cognitive processes were triggered and directed by one's emotional state. Hence, they believed that learning was fostered under relaxed circumstances and stifled when stress was present.

Besides sharing vivid conceptualizations of knowledge moving back and forth in the brain during learning experiences, co-researchers also conveyed the profound impact that emotions had on their ability to learn. They shared stories of knowledge being inaccessible or "stuck in the back of the brain" during emotionally charged states that they associated with situations such as SA and power differentials in student–instructor relationships. They claimed that stress and its associated nervousness impaired their ability to bring knowledge to awareness and, consequently, negatively influenced their clinical performance and the associated learning. A number of physical symptoms were experienced by co-researchers when they perceived that they were under stress and they believed that those symptoms constituted an additional barrier to their learning. They shared similar accounts of having experienced distressing symptoms, such as sweating, shakiness, facial flushing, decrease in self-confidence, inability to focus, and anxiety, which intensified when they knew they were assessed summatively and the fear of academic failure arose.

Besides resenting the fact that doing guided reflections was time-consuming because of the required narrative format, they also expressed a common desire for more time with their clinical instructors so that they could get feedback on the reflections as well as on their clinical performance. Hence, feedback associated with FA and additional time spent discussing feedback surfaced as a key factor to foster learning in clinical courses.

One particular concept that stood out in the co-researchers' accounts was their unique perception of classroom and clinical courses. They viewed classroom-based nursing courses as theoretically focused academic courses where the use of SA was anticipated and indisputable. Conversely, they believed that clinical nursing courses were exclusively focused on nursing practice and that their unique purpose was to provide experiential learning aimed at enhancing students' knowledge of nursing and of their nursing practice. Interestingly, when students shared their views and beliefs about clinical courses, they referred mainly to their practical nature, and some even admitted that they did not consider them to be courses in the academic sense of the word. Hence, because of their idiosyncratic view of clinical courses and because they believed that FA fostered relaxed spaces for learning where deeper knowledge could be constructed, co-researchers identified FA as the most effective approach to foster critical thinking and deep learning, and, consequently, to enhance students' practice of nursing. On the other hand, because they viewed SA as a significant barrier to learning; they believed that its use in clinical courses should be minimal.

Co-researchers viewed their instructors as facilitators of learning and they used various metaphors to allude to the guiding and supportive nature of the clinical instructor

role. They valued respectful mentorship with their peers and with others working in clinical settings; however, they identified clinical instructors as the most influential persons in their learning. For them, the instructors' approach to SOTL was instrumental in determining the nature and the quality of learning situations where students performed nursing care. Individual personality traits and attitude towards students were also identified as powerful factors in the learning experience.

Synthesis

The fourth and last fundamental process of transcendental phenomenology is *synthesis*. It involves the integration of the universal textural meanings—the *noema* of the experience and the universal structural meanings—the *noesis* of the experience into individual textural-structural descriptions and a composite textural-structural description described by Moustakas (1994) as a synthesis of meanings and essences.

In adherence to Moustakas's (1994) approach, individual textural-structural descriptions were constructed for each co-researcher, followed by the development of a composite textural-structural description. The following are examples of the individual textural-structural descriptions developed for Julia and Rose.

Individual Textural-Structural Descriptions

Julia. Julia's experience of assessment was fuelled by her self-confidence and her active engagement in learning to become a nurse. As an older student with extensive life experience, she was convinced that she had the potential to be successful in the program. Julia admitted that she never worried about going to clinical as she felt that she could deal with problems as they arose: "if I'm ever uncomfortable, where I'm feeling like I'm not meeting an expectation, I would work with the instructor before it came to

the point where I would be worried about failing." Because she believed that students are responsible for their own learning, Julia sought learning opportunities whenever possible stating, "You have to be proactive in these experiences, you can't just sit around and expect that somebody is gonna come take you and show you something. If you want a good experience, you make a good experience for yourself." She further explained, "all you can do is jump at every opportunity you get and try and learn as much as you can."

Because Julia was confident in her ability to be successful in her nursing program, she admitted to feeling comfortable to approach clinical instructors for help: "If there's something that you don't get right, you know you discuss it but I don't feel like it's ever really graded so I like that aspect of it." Because she viewed clinical courses as exclusively practical in nature, Julia believed that they were only assessed formatively; "you don't really think of it the whole time, you don't think oh I need to do this or I'm not going to get that grade. I find it alleviates a lot of the stress." Because she didn't consider clinical experiences as part of a formal course, Julia was oblivious to the summative aspect of clinical courses:

> I enjoy that you don't have grade associated with it because again every experience will be different for every student so I think if you're meeting these core abilities and competencies and you're working with your instructor to develop these, I think that's more valuable for the clinical experience than it would be to give us grades.

Julia believed that feedback was essential to learning and key to enhancing her nursing practice.

> The only way you are going to learn is if you get that feedback and it's a progressive thing that you just kind of add; you change things along the way. If you're hearing like oh you know that was good but you could maybe try and do this next time, again it's just adjusting your routine and your skills to find what works best for you and what works best for the patient obviously and that's how you develop those skills and abilities.

She believed that feedback gave her confidence and it enhanced her motivation to remain engaged in learning; "the first time is always the most nerve racking but after you receive feedback and you kind of have a feel for it, then you gain confidence I guess. And you feel comfortable enough to do it again." Recognizing that students need time to learn, Julia noted, "no student is going to get a skill or something in the clinical setting right necessarily the first time." Julia believed that getting feedback "makes you feel competent" and she explained that it

> actually makes you feel like, ok I can do this and you know maybe I won't be half bad being a nurse after all. Because a lot of days, you question; am I doing this for the right reason? So it's nice to get that feedback from your instructor, hey that was a really good job or maybe we could try this next time.

Julia found clinical courses demanding and she resented the amount of work required to meet course requirements.

> As students, some days, it kind of frustrates you that you are putting so much work into a pass or fail kind of course. But for something like clinical, I think it's more valuable to do a formative assessment for students than it is to put a number to it.

When asked to clarify her last statement, Julia explained, "you don't really think of it the whole time, you don't think oh I need to do this or I'm not going to get that grade. I find it alleviates a lot of the stress."

Julia provided a graphic illustration of her perceived relationship to others when she used the following metaphors to illustrate the role of clinical instructors: *mother hen*, *security blanket*, and *guide*. Using the metaphors of the mother hen and ducklings to illustrate the protective role of instructors and the dependence of students on their clinical instructors during the initial period of clinical placements, Julia noted, "the first couple of days on any new clinical placement, we're like the little ducklings following the mother hen." She believed that the instructor role changed as students spend more time in the clinical setting and gain experience; "the further you go into it, the less you have to follow the instructor along and you're just gaining your independence."

Julia also used the metaphors of security blanket and guide to illustrate her conception of the instructor role, and she expressed melancholy as she pondered about her future career where she would be expected to practice independently without the feeling of security that she associated with having a clinical instructor available for support and guidance: "It's like a security blanket and it's only starting to sink in now that soon enough we're going to lose that security blanket and it's scary to think of." While she also viewed instructors as guides, Julia was cognizant that students are expected to develop independence.

> I think that's the goal basically, is to gain that independence and that comfort in the clinical setting but know that if something arises, I have that person there to turn to. And they'll be able to help me out or if I have something new.

Julia viewed instructors' approach to student learning as a significant factor in shaping the type of nurses who graduate and the nursing specialty where they choose to practice. "I find some of those clinical experiences could really shape where you end up choosing a career." To further illustrate the critical role that she attributed to nursing instructors, Julia used the example of one clinical instructor she had in the past:

> I felt like I learned so much and retained so much just in the small period of time that I was there and it was very much because of who the instructor was. You could tell she's passionate about her work there.

Referring to a less positive experience, Julia stated, "I know that I should not shut down the idea of being in [name of specialty setting] but because of this experience I have no desire to go there [to work as a RN]."

Rose. Rose's experience of assessment in clinical courses was influenced by her conflicted view of guided reflections as tools for learning. Because guided reflections were required in narrative format, Rose found them time-consuming and she questioned their purpose; "when I'm writing them I feel like this is a waste of my time because if you're not graded on it, what's the point in doing it." Nevertheless, she recognized the formative nature of guided reflections when she shared,

> I do understand the necessity of it, where you're supposed to look back at an experience and think critically about what you did, how you can improve next time, what things can be changed and things like that. And it's just trying to provide a more holistic perspective.

Rose admitted to investing less time on assignments that were assessed formatively; "it would be different, I would put more time and more effort and I would

make it a little bit more scholarly, if it was being marked. Showing my instructor that I had put thought into it." She added:

> Since it's formative, I wrote it down and I did a really good job at it but once it was done, I just submit it. I just don't put as much effort into it. I think if it was summative, I probably would reflect on it a lot more and I would really try to dig deeper into what I was thinking and feeling.

Rose disclosed putting more efforts in summative assignments.

> Just because I know that's graded and I'm being marked on it, I would pay more attention to detail and I would make it more thorough. Maybe I would have consulted textbooks and things like that and would have had research to back up my opinions and what I thought. It would be different.

Although Rose despised the writing aspect of guided reflections, she recognized their valuable purpose; "it's trying to make you a better critical thinker, trying to get you to think outside of just yourself and what you did." Recognizing the debriefing aspect of guided reflections following emotionally charged clinical situations, Rose noted that they helped her gain perspective, resulting in richer knowledge and enhanced nursing practice. She shared a traumatic situation where completing a guided reflection was beneficial to her.

> It was good for me, for the guided reflection to just sit down after that had happened and just reflect on what I'd done, what I felt that I could do differently and just trying to not blame myself for the situation.

She added, "the guided reflection actually helped me sort through my emotions because it was very emotionally charged and it was like nothing I'd ever experienced before."

Finding that this specific FA helps students narrow in on specific situations, Rose shared that for her "the guided reflections and just those assessments, helped me put it more in perspective and have me think about it logically, instead of being emotionally based." After completing a guided reflection, Rose "could put my emotions aside and I was able to look at just the situation with clear, more focused eyes," where

> I was able to really understand everything that I did, everything that I could have done and if I'd reacted appropriately. If I didn't [react appropriately], how could I change it to better my practice if that situation ever comes up again.

Rose claimed that getting formative feedback on a guided reflection of an emotionally charged situation added another dimension to her learning.

> I just felt like I learned more and I felt like all of my questions were answered. I understand the situation. I understand what happened, why it happened, what events lead to it and what intervention could be done to help it.

After discussing the situation further with her instructor, Rose "knew for certain if that were ever to come up again, I would know what to do and how to do it." She also found that "to sit down and just talk about it, I think that it was very cathartic."

Rose believed that the use of evaluative strategies and SA in clinical courses created stress that intensified power differentials and consequently impacted her performance.

> If there is that dichotomy of a power imbalance; I would feel like there would be a lot more pressure. I would be under a microscope more and I would be afraid to make mistakes because I would be graded on it.

To illustrate her statement, Rose described a specific clinical event where she viewed one of her student–instructor relationship as a hierarchy; "it's just the authority. I'm not as good at connecting with her on a human level as much as I was with my other instructor." She gave an example of a different situation where she viewed a clinical instructor as a an equal:

> At that time I was crying, I felt really upset and it was just good that she could just sit down and we could have like a human conversation. Nurses, you know like nursing student and nurse, like it's not an student–instructor where there is a hierarchy. It was just two people sitting down and talking about something that was traumatic.

Seeing her instructor as a nurse humanized the instructor and the student–instructor relationship.

> It was just a relief that I could connect with somebody and they really understood what I was saying, it was reassuring for me. Just having somebody there who understands, lives that as the nurse, does that every day and experiences things like that.

For Rose, having the opportunity to discuss a traumatic event with her instructor meant that she

> took more away from that experience because I could talk to her whereas if I had a different instructor and you know I felt like I couldn't talk to her or share my emotions or opinions, I don't feel like I would learn as much. If I was with an instructor and I couldn't express what I wanted to, I would leave having questions and they would be unanswered. I wouldn't know in the future what I should do or

> what I shouldn't have done because my questions weren't answered or my opinions weren't heard.

Rose admitted that because she felt that she was more prone to making mistakes during SA, she stayed away from instructors when she was aware of being graded. Consequently, Rose admitted that she learned less under summative circumstances. She pondered,

> If I had another instructor, I probably would still have questions and I would still be unsure of myself because I didn't have that reassurance or that acknowledgement that I had done some things right. And, I wouldn't have known what to do differently.

Rose recognized the potential impact of clinical instructors on learning.

> An instructor should have the know-how and the knowledge to be able to guide me as the student, to help me with developing my nursing skills and my nursing practice so someday, I will be that nurse that will know what to do because of the experience that I've had before and the instructors and the people that I've been able to work with.

After reflecting on the student–instructor relationship, Rose stated, "I realize that I am a student, I am learning and my instructor is there to guide me if I have any questions." Reflecting on the instructor role, Rose noted, "she's more of a guide; she's just there to help me as I learn and to facilitate learning."

Referring to a personal situation where she viewed her instructor as a guide, Rose used the terms *human* and *horizontal* to describe the level of connection she felt. For her, an instructor who is a guide "will facilitate as much learning as I can absorb." Evidence

of a perceived hierarchy was attached to Rose's conception of one particular instructor's guiding role; "she was also a guide but I could connect with her on a more human level, just a more horizontal level." To further illustrate her concept of horizontal learning, Rose explained, "if you're working with somebody and you're learning with them, the experience is much better." She continued, "if it is horizontal learning where you go through something together, you can connect more and it's just a richer experience."

Composite Description of Meanings and Essences

The last synthesis process within Moustakas's (1994) approach to data analysis is an integrative activity where the researcher is expected to "develop a composite description of the meanings and essences of the experience, representing the group as a whole" (p. 121). The synthesis or composite description that follows represents the essence of the phenomenon from the co-researchers' point of view at a precise time and place. The co-researchers who volunteered to participate in this study stand as experts in their lived experience with FA formally embedded in clinical nursing courses. The meanings embedded in their stories were uncovered after intensive periods of in-depth reflective and imaginative activities guided by the approach outlined in the "modification of the van Kaam method of analysis of phenomenological data" (Moustakas, 1994, p. 120).

The *noema* and *noesis* of the phenomenon were universal to each co-researcher; however, to prevent redundancy of statements that were included in previous examples, most quotes integrated in this synthesis were extracted from the interviews shared by Venita, Ariel, Erika, and Louise. The following composite description brings to light the

qualities and essences of what it is like for students to experience assessment when FA is formally embedded in clinical nursing courses.

Cognition and learning lay at the heart of each co-researcher's narratives as evidence of metacognition was shared. Evidently, as they pursued their goal of becoming nurses, participants believed that constructing and using knowledge happened in the brain and that it was key to developing competence as well as to succeeding in their nursing program. They shared the belief that experiential learning under FA conditions enabled the cognitive processes that were responsible for bringing forth the knowledge that they needed to perform nursing care.

Using different metaphors, co-researchers alluded to knowledge as a moving entity directly influenced by the nature of experiential learning and the emotions at play. Thus, positive emotions associated with FA were viewed as catalysts that facilitated learning by keeping the knowledge easily accessible in the forefront of the brain. On the other hand, negative emotions associated with perceptions of being assessed summatively were viewed as obstacles to cognitive processes because students believed that anxiety overrode their ability to use and construct knowledge during emotionally charged learning experiences.

Co-researchers conveyed varying levels of awareness of the higher mental processes at play during their learning. They viewed the brain as a mechanical entity where cognitive processes such as knowledge construction, memory, attention, and consciousness occurred. Many used graphic metaphors to explain their understanding of cognition and offered detailed verbal illustrations of their understandings. For example, Ariel conceptualized the brain as a stove, which implied that her knowledge was located

on the front or on the back burner depending on the learning conditions. The concept of the front burner was directly related to consciousness or her focus of awareness during a learning event while the concept of the back burner implied the presence of a space in her brain where learning was stowed for safekeeping until needed. Other participants also referred to knowledge remaining on the back burner or in the back of one's brain when anxiety was present. At such time, they believed that anxiety related to SA or their perceived fear of failing the course took the center stage of their consciousness and became the dominant focus of their learning experience. As explained by Ariel, "when you're doing something for the first time and my nerves get in the way, that's all that I focus on." During those anxiety-filled times, participants admitted to having difficulty retrieving the knowledge that they needed to perform a skill or to answer questions. Consequently, they suggested that clinical performance and learning were negatively impacted by anxiety associated with SA and the fear of failing clinical courses.

Besides sharing vivid conceptualizations of knowledge moving back and forth in the brain during learning experiences, co-researchers also conveyed the profound impact of emotions on their ability to learn. They shared stories of knowledge being inaccessible or "stuck in the back of the brain" during emotionally charged states that they associated with situations such as SA and power differentials in student–instructor relationships. As explained by Ariel, "the more confident I get, the more the knowledge goes up front, the more the nervousness and the physical aspect of my body being nerves, that goes on the back burner." She added, "if I don't build the confidence [laughing] then it's gonna stay in the back a little longer." Overall, co-researchers claimed that because stress associated

with SA impaired their ability to bring knowledge to awareness, it negatively influenced their clinical performance and the associated learning.

For some, seeing the brain as a storage space implied an area in the brain where knowledge was kept for indeterminate periods but was accessible for retrieval if needed. Thus, co-researchers believed that knowledge remained stored until they were faced with specific learning situations, at which time, the related knowledge moved forth to awareness so that it could be used as required. As explained by Venita,

> It's in the back of my head to start with but whatever situation may arise. If there's a wound in front of me, I know ok, well this here is some purulent exudate and that's a little granulation tissue. You actually see it, it's tangible. So it comes forward.

The concepts of doors and lights were used by Louise to explain learning and her progress in the nursing program. Viewing her nursing studies as a journey through dark and shadowy spaces, she explained,

> Starting out in first year you know nothing so all the lights are off. Second year, it's like someone just opened the door and let in a little bit of light, you're starting to make a few connections here and there but you still don't really know much. By third year, the second term of third year, people are starting to flick on the lights now. You're able to see what's going on; you're able to start predicting what's going to happen to your patient. You get to the point where you know you're gonna be fine. You can start to predict more about how they might react to certain medications, and oh but then there's still surprises everywhere you go.

She further explained, "you start to feel like things are gonna work out, there's a light at the end of the tunnel and those bright lights come amongst a whole lot of shadows." Co-researchers' unique conceptualization of classroom and clinical courses was particularly interesting. Classroom-based nursing courses were considered courses where theoretical content was delivered and learned. On the other hand, co-researchers believed that clinical nursing courses were exclusively practical in nature and that their unique purpose should be to provide experiential learning aimed at fostering the construction of nursing knowledge. When referring to FA in clinical courses, co-researchers believed that it fostered relaxed spaces for learning where deeper knowledge could be constructed. Hence, co-researchers identified FA as an effective strategy that enabled them to develop their critical thinking skills while feeling safe to learn. Under such conditions, co-researches shared that their nursing practice and performance was enhanced. To elaborate on her conception of FA fostering a safe space for learning, Venita explained,

> You're able to actually go out and try things and not be worried all the time. For example, if I am doing a dressing change and I break sterile field, I'm not gonna fail. I can get another tray and start again without the fear of failing.

Co-researchers viewed SA as a significant barrier to learning; they believed that its use in clinical courses should be minimal. For example, Erika believed that summative assessment was more suited to theory courses and that they required memorization in order to meet graded examinations. She felt that the content taught in classroom courses essentially had to be learned so that one could write tests and exams. Hence, she did not attach much importance to theory content from classroom courses, as exemplified by her statement that "I feel like I care about my learning more in clinical

than I do in class because you can get by in class. In clinical, you gotta know your stuff." Erika admitted feeling more involved in her clinical courses as seen in her expression that "I just find I'm more engaged because there's a lot more responsibility in clinical. Rather than in class, there's really not any responsibility." She further explained that, "in the classroom, it's a lot more summative because you're learning the stuff so you can write a midterm or a final for it, I think more memorization, it's not like I'm actually learning it to understand it much." Erika felt that "in clinical, I'm gonna have to know this again and my instructor is not gonna keep coming with me and showing me. You actually try to go home and make sure you remember it." Erika perceived that, in clinical courses, she was expected to show evidence of her knowledge in the form of critical thinking and safe nursing practice. Thus, clinical courses were more important to Erika because she believed that the sense of responsibility attached to practice courses required a deeper understanding of the knowledge applied to practice situations.

Venita admitted that when she was assessed summatively in clinical, she was more prone to mistakes and she focused on instructors' expectations and on her grade rather than on the valuable learning that could be constructed. Venita expressed her belief that under FA situations in the clinical setting, physical factors or distractions, such as temperature, noise, and anxiety, did not affect her because she was comforted by the fact that she could rely on her instructor if the need arose.

In the nursing program where the co-researchers were enrolled, each clinical course required students to complete two narrative guided reflections that were formally embedded as FA. Criticism about the written format of these assignments was widespread; however, every co-researcher acknowledged the valuable learning potential

of such assignments because of the feedback they provided.

Initially, Louise was suspicious of the true purpose and nature of guided reflections and wondered if they were really going to be exclusively formative. She stated that

> I didn't like doing reflections in the very beginning, mainly because I didn't understand really what they were aiming at, what we were doing. The first year and part of second year, you don't really know what you're expected to put there. You don't know your instructors that well, so you don't know what they're looking for. They say there's no mark, but is there really? As time goes on, you get used to it.

As she progressed in the program, Louise developed an appreciation for guided reflections and found that they helped her develop critical thinking to the point where she espoused the habit of consistent reflective practice. This point was brought out in her statement that

> after probably the second term of second year, things are really coming together and your reflections are very helpful. In a manner, so much now, that I wouldn't even necessarily need to write them, because I will just take the time at home and think about different incidences when it's time to write them.

Because Louise did not worry about grading when she wrote her guided reflections, she admitted that she was able to go deeper and think critically about her practice without apprehension. She stated, "I probably go deeper because I'm able to really process in my mind what's going on as opposed to trying to make it clean cut, concise for marking purposes." Louise found that guided reflections "help guide you to

the right answer or whatever which is great because then you're linking, putting the connections in place for yourself." Furthermore, she shared that considering other perspectives helped her distinguish what was satisfactory in her practice from what needed to be changed in the future.

Co-researchers valued guided reflection as a FA strategy to foster critical thinking and credited the associated feedback with enhanced nursing practice and deeper reflective skills. Evidence that FA shaped Ariel's experience of assessment and contributed to enhancing her nursing practice was expressed in her following statements: (a) "taking that feedback with me it's just a learning experience, I like knowing what I do right but I also like knowing what the heck I did wrong," (b)

> The only way you are going to learn is if you get that feedback and it's a progressive thing that you just kind of add, you change things along the way. If you're hearing like oh you know that was good but you could maybe try and do this next time, again it's just adjusting your routine and your skills to find what works best for you and what works best for the patient obviously and that's how you develop those skills and abilities.

and (c) "it benefits me mentally for my self-esteem, it benefits my learning, realizing that I can do this, it benefits me. It benefits the patient, they're confident in your skills, they see you happy."

Co-researchers wished for more formative feedback on reflections and on their clinical practice because they viewed it as essential to learning to become a nurse. They believed that FA provided clarity about their strengths and areas for improvement; it also contributed to increased self-confidence and enhanced motivation to be self-directed.

The different perspectives uncovered through feedback associated with FA can enhance students' knowledge, shape their practice, and prepare them for future clinical situations. As stated by Venita, "I probably learn 60% from feedback and 40% from writing it." She added "the feedback from guided reflections help you focus in on your practice and decide where you need to work on, where your strengths lie et cetera."

Lack of feedback resulted in students' perceived ignorance about their progress in clinical courses, which Erika likened to "being in the dark." She believed that FA and its associated feedback fostered her learning by keeping her informed about her strengths and areas of needed improvement. Appreciating the explanatory nature of the feedback that she received during FA, Erika noted, "you know you're doing all this work and it's paying off. If it was the opposite and you wasn't [*sic*] doing very good, then you would know that you had to work harder." Hence, through the feedback provided by instructors, Erika felt comforted because she was aware of her standing in the course and she knew if, and on what, she needed to improve. Consequently, she claimed, "the more feedback the better because then you are not in the dark."

Louise's affinity for face-to-face communication and her preference for verbal feedback shaped her experience of assessment. She favoured feedback that was done orally, as expressed in her statement that

> you're doing your reflections except this time you're right there doing your reflection verbally with your instructor and or sometimes, you do it with your classmates. They're giving you the opportunity to go on so you can figure what went wrong.

For Louise, valuable feedback came from discussions with instructors, peers, and staff nurses, and it provided her with opportunities to reflect on practice "sometimes not even talking to the students and the instructor, go talk to the actual staff that are working there and you can get feedback from them as well which is really fantastic."

For co-researchers, FA was viewed as liberating and stress reducing. For them, not being graded when assessed by instructors tapered their fear of failing and lessened their apprehension about being judged. Hence, they felt that they could be candid while sharing personal feelings and emotions, verbally and in writing, during specific learning experiences in clinical courses where FA was used. Ultimately, they associated the freedom to be real and the freedom to be honest with FA in clinical courses. Sadly, as explained later, co-researchers believed that, for some students, SA triggered the compulsion to deceive and to hide true abilities in order to succeed in clinical courses.

Co-researchers believed that FA fostered free and open sharing of students' personal emotions regarding their nursing practice and they also believed that it fostered a sense of "being able to say the truth." Miranda admitted that in the context of FA, she felt safe to talk freely about her own thoughts and feelings and even referred to FA as liberating. She liked the fact that FA gave her information about her performance without the evaluative aspect of a grade. This point was expressed in her statement that "if you're really screwing something up, they're gonna let you know anyways and help you figure it out. But you're not at risk of going, oh geez, I got a 42 on that test."

Louise alluded to her ongoing concern about being judged and appreciated that in FA situations students are kept abreast of their performance and can be guided to improve as needed in an environment that she described as liberating. She shared the belief that

she gained self-awareness and self-confidence from FA and that it kept her motivated to persevere towards her professional aspiration of becoming a nurse. During a situation where she was formatively assessed, Louise explained, "I gained a lot of confidence right at that time, there was no, you should have done this, you should have done that. Nothing like that, it was you did a really good job, the only reason it bled at all is because of this. There was nothing negative about the experience. So the second day, I was able to go no problem with the instructor and just do it. And the third day, go in no problem by myself." She added, "it makes you feel like you're going somewhere with this, it's a confidence boost without getting too confident. You feel like you can move on to the next step. So from that perspective I know I'm able to move forward." Louise appreciated the fact that FA "gave me the opportunity to really think about the potential consequences."

The potential for learning within a culture of FA was universally acknowledged because all co-researchers expressed higher levels of engagement in their learning when they were aware that they were not being graded on their clinical performance. They believed that FA provided a relaxed environment where deeper knowledge was constructed and integrated into their practice of nursing. Hence, all co-researchers claimed that FA was more conducive to learning than SA by recognizing that FA provided students with calmer environments and favoured learning; they believed that it resulted in enhanced ability to see other ways of being and doing. Consequently, while learning from FA situations, students were more open to other perspectives and they shared being comfortable to try different approaches witnessed from instructors and other mentors.

All co-researchers believed that FA enhanced the teaching–learning environment and contributed to learning. Ariel explained how she favoured the process of FA, as inferred from her statement that "from my personal experience, formative assessment is the way to go because my knowledge is in the front, my nerves are in the back. I can learn more, it's a positive experience, it benefits me." She added that when assessed formatively, her stress level was manageable. She said "my self-esteem goes up. I feel like this is not easy-peasy but I can do this, it's doable." Ariel admitted to feeling comfortable and relaxed in situations of FA.

Participants believed that a culture of FA lessened the stress associated with supervised clinical performance and that it consequently fostered safer student practice. For example, when asked to elaborate further about the experience of learning under FA circumstances, Ariel stated, "it's a wonderful feeling to have that knowledge up front and the nerves in the back. When I have that knowledge up front; the clients are so relaxed, they're talking to me and most the time, we have a great time if they're not real, real sick. I just find the whole experience is a lot better learning experience for me and for the client and having that knowledge up front is wonderful." Ariel referred to the use of FA in clinical courses as a 'win-win' situation for students, instructors, and patients.

SA was a significant element of each participant's stories, and it was viewed in a predominantly negative light. Attributes that co-researchers associated with SA implied that SA created an invisible imaginary wall that hindered their learning. The ostensible obstacles to learning that students attributed to SA were synonymous to a perceived wall. The presence of an invisible barrier or wall between students and learning was evident in all of their stories associated with stress and SA. Ultimately, they believed that SA

potentiated stress and accentuated their fear of failing clinical courses, thereby rendering their cognitive processes idle and hindering learning during clinical experiences.

Co-researchers shared vivid conceptualizations of knowledge as a dynamic entity moving back and forth in the brain depending on the emotional conditions perceived during learning experiences. They shared that the emotions they felt during specific learning experiences significantly impacted their ability to learn. Common were stories of knowledge being difficult to access or "stuck in the back of the brain" when co-researchers perceived that they were being graded. They identified the stress and anxiety associated with summative situations as detrimental to their ability to access knowledge and, perceived that such conditions negatively affected their clinical performance and their ability to learn in the clinical setting.

Co-researchers viewed stress as a barrier to learning, and they believed that their stress was decreased by FA and augmented by SA. Interestingly, Holly expressed feeling a sense of obligation and she admitted that rather than concentrating on learning, her efforts were focused mainly on meeting academic requirements when she was aware of being graded. She referred to SA as "a cloud on your shoulders" and she believed that her clinical performance was impaired and her learning stifled by SA. She associated FA with a sense of freedom from academic performance anxiety. Holly construed a clear divide between her learning under FA circumstances and her learning constructed under SA. She believed that learning constructed during SA situations was more mechanistic or skills oriented, and she felt that it focused mainly on the general nature of the theoretical content that was learned. Consequently, Holly's view of assessment resulted in her interpretation of SA as "minimally useful" and merely an academic requirement.

Conversely, Holly viewed her learning derived from FA as holistic. She believed that it focused on deeper integration of theoretical content and fostered further learning.

Because she felt that FA promoted transparency of the assessment process, Venita acknowledged that it provided space for learning and time to improve one's practice without worries about academic failure.

Feeling responsible for patient safety and wanting to successfully pass their clinical courses, co-researchers experienced pervasive levels of anxiety whenever they were in the clinical setting, although most admitted that their level of anxiety intensified significantly when they perceived that they might be assessed under SA conditions. They acknowledged that a subtle state of anxiety was acceptable because most believed that it prompted them to be more attentive as they practiced. Because of the importance that she attached to patient safety, Erika admitted feeling nervous even knowing that she was being assessed under FA circumstances. She reported feeling a certain level of stress whenever she was in the clinical setting. This was evident from her statement that "you have responsibilities in clinical, you don't want to put your patient at risk, so you want to do everything right." However, Erika believed that it forced her to be mindful during her nursing practice, as inferred from her words that "being a little bit anxious kind of keeps you on your toes."

For Ariel, emotions associated with specific learning experiences created memories that could potentially impact future learning. She shared that memories of negative reactions lingered and could surface "on the spur of the moment" whenever she found herself in future SA situations. She believed that such memories contributed to "get the ball rolling" and promptly activated another physical reaction, "but once it

happens, my brain doesn't forget that that's how the brain reacted to that situation. So when I go do it again automatically it pops up like Oh my God last time I did this Oh God. Then my nerves start." Upon further reflection, Ariel added, "the next time I do do it, I don't forget about my previous experience. I don't forget thinking of my gosh, am I going to react the same way? So once again that kind of gets the ball rolling of my nerves and then most the time I just have to say you either gonna have to calm the heck down or you're gonna fail, and then you know the self-esteem goes down and the whole nine yards." The lasting impact of emotionally charged learning situations on Ariel, whether positive or negative, was especially evident when she shared, "if I have a bad experience, my brain knows that the next time I do it. When I have good experience, the next time I do it, my brain knows that so the nerves are put in the back."

For co-researchers, co-learning not only implied learning from and with others; it encompassed the unique rapport with their clinical instructors as well as the nature of the learning environments that those relationships fostered. Co-researchers used various metaphors to describe the guiding and supporting nature of the clinical instructor role in the teaching-learning process during clinical experiences. They valued co-learning with their peers and with members of the health care team working in various clinical settings; however, they perceived their clinical instructors as the most having the most impact on their learning. For co-researchers, how instructors' taught and their approach to students was an important factor in determining the nature and the quality of the clinical learning situations as well as their learning.

The nature of the relationship between nursing students and clinical instructors was viewed as critical to the experience of assessment and to the process of learning to

become a nurse. Although important, the level of nursing expertise that clinical instructors had was viewed as less influential than their approach to the SOTL. Participants believed that learning was enhanced and their clinical practice significantly improved when clinical instructors consistently used FA and fostered a climate of mutual respect during clinical performance. They favoured FA to SA, because they believed that it fostered safe student practice resulting in safe patient care. Evidence that FA fostered critical thinking, flexibility in practice, and adaptability to change was prevalent in all of the co-researchers' descriptions of their experience with assessment. Overall, co-researchers wished for a pervasive use of FA in clinical courses, because they believed that it would contribute to graduate competent nurses who possess the ability to adapt to the ever-changing nature of clinical environments.

Co-researchers recognized the contribution that nurses and other health care team members had on their learning. For example, Holly acknowledged the valuable contribution of staff nurses and she suggested that a more pervasive integration of FA in nursing schools could lead to future nurses being more aware of staff nurses' impact on student learning. She hoped that, consequently, they might be more open to welcoming and teaching students in their areas of practice. Ariel's relationship with others, specifically clinical instructors, and their approach to the teaching–learning process was a significant factor in her experience of assessment. She believed that the quality and quantity of knowledge derived from clinical experiences was directly related to instructors' approach to SOTL and by the type of assessment conducted. In instances where she perceived the presence of a personality clash or conflict with her instructors, Ariel experienced stress, which eventually led to physical and psychological symptoms

that she believed interfered with her performance and, ultimately, her learning. Similar reactions occurred when Ariel perceived that she was performing in summative assessment contexts. Relating a bad experience in the clinical setting, Ariel shared, "I thought, she must not really care for me so that really influenced my learning because like I said, the communication between us wasn't real great, it was just stressful." While performing a catheterization under instructor supervision, Ariel explained, "she went in so I thought, OK here I am, she's grading me off of this and it was a horrible experience like my nerves, knowing that she was grading me. It was very nerve racking, I didn't like that." She continued, "I felt like a big dummy. I felt like I had no self-esteem because I was so nervous. Plus the attitude between us two didn't help." As a result of this situation, Ariel came to question her own professional aspiration: "So I had no self-esteem and then I got thinking, Oh my gosh if I can't put a catheter in, how the heck am I gonna be a nurse? It was a horrible feeling, I just felt like no self-esteem. I felt I couldn't do this, I thought maybe I should look at another career choice, maybe I should not continue. And I'm sure it would have been a better experience if I had another instructor on another previous clinical."

Using the metaphors of the mother hen and ducklings to illustrate the protective role of instructors and the dependence of students on their clinical instructors during the initial period of clinical placements, Julia believed that the instructor role changed as students spend more time in the clinical setting and gain experience. Furthermore, she used the metaphors of a security blanket and a guide to illustrate her conception of the instructor role as a source of support. Julia expressed melancholy as she pondered about her future career where she would be expected to practice independently without the

feeling of security she associated with having a clinical instructor available for support and guidance. Julia believed that instructors' approach to students shapes the type of nurses they become as well as the nursing specialty within which they choose to practice. For Erika, instructors' approach to teaching and learning, specifically the quantity of the feedback they provided, significantly impacted her learning, as indicated by her statement that "it depends on the instructor because some instructors are really open and throughout this clinical you're gonna know if you're doing good or of you need to improve on something." She went on to say, however, that "some instructors don't give a lot of negative or positive feedback. So I feel that with those kinds of instructors, you're in the dark."

Erika admitted that being supervised by an instructor was stressful, even in formative assessment situations. As she explained it, "it's not like the summative assessment that they're gonna mark but they're still looking at what you're doing, how you're interacting with the patient and everything." Alluding to the degree of nervousness she felt when supervised, Erika explained that

> there's also that kind of nervousness because we're supposed to know what we're doing. But we can't know everything perfectly. It makes you more comfortable for the situation but then it's kind of a bit stressing too, I suppose, cause you do know that they're there.

Nevertheless, Erika acknowledged that "having that instructor there makes you more comfortable. Because I know the patient's best interest is gonna be there. Because if I'm doing anything wrong they're gonna correct me or help me." Referring to a personal

experience where a particular instructor's approach meaningfully influenced her learning, Erika shared that

> it completely depends on the instructor. My [name of specific nursing unit] rotation, my instructor was really nice and everything but she was strict so when I was doing things with her I guess I was a little bit nervous which kind of which makes the experience different.

She further explained

> I do better with more laid back instructors that do expect a lot from you but that doesn't [*sic*] come off in a negative or like scary manner. You're not scared to ask them questions, if they're more laid back and you know that you can go talk to them. You can ask a question even if it might be stupid then you're gonna have more learning out of that. If I was always scared that I didn't want my instructor to know I didn't know something, I might not ask all the questions that I would with an instructor that I was more comfortable with. It's a good feeling, it's just like low stress.

Using the metaphor of a crutch to refer to one instructor, Erika stated, "I knew I would be able to ask her any questions if I needed to and if I was doing anything wrong she would be there. I kind of like to have that crutch until I get good at the skills." Erika shared how her sense of engagement in learning was fostered by past instructors: "I've always had really good instructors that were good for my learning."

Venita used the metaphor of the mamma bear and her cubs to describe her view of the ideal student–instructor relationship and noted that it should be a mutually respectful relationship where the goal is to guide students towards increased levels of independence

in their clinical practice. The mamma bear metaphor was further exemplified when Venita admitted that she appreciated having the clinical instructor as a protector from unsafe practice for her and her patients.

Overall, co-researchers believed that FA fostered safe learning environments resulting in valuable learning. They also found that they learned at a deeper level when FA was involved. Conversely, they claimed that they learned less under summative circumstances because of its potentiating effect on stress. Many alluded to the fact that mutually respective relationships between instructors and students in nursing schools may result in students being more inclined to trust knowledge experts in the future as they practice as nurses. Ariel felt that the instructor's approach to SOTL was key to an effective teaching–learning process: "It's all in your approach and in your tone." To convey her belief that instructors had a significant influence on her learning experience, Ariel compared clinical experiences she had with two different instructors: "Every nursing student told me you're gonna have one instructor that makes you cry. I had my one instructor, so hopefully, knock on wood, that will be my only one." Zoning in on one specific experience and how the relationship influenced her learning, Ariel noted "that whole clinical experience was terrible. It was just the relationship that me and that instructor had." She continued:

> It was just really crappy to be perfectly honest but with my other instructor for [name of setting], from day one, when you asked her a question she didn't look at you like you had horns like the other instructor did.

Elaborating on her experience with the latter instructor, Ariel explained that

> she was there and that really didn't make me nervous, I enjoyed her being there. Once again knowledge is in the front, nerves are in the back; went in, did it, had a wonderful experience, came out, and she gave me feedback. She would take the time, I'm sure she explained it so many times to people but she didn't make me feel that way, it was wonderful. Right then, it was just the way that the instructor communicated with me. And not only that, it made our group more relaxed and which was better obviously for the instructor.

Relative to this specific FA situation, Ariel noted, "I learned but it was relaxed." Ariel very much appreciated the formative approach of this instructor and stated, "I thanked the instructor so much for doing it that way and I told her you really got my confidence up where it was so low." She added, "it benefits me as a student and not only that, it benefits the client, and it just makes everybody happy."

Instructors' approach towards students was directly linked to power differentials between instructors and students. They believed that learning was enhanced when it stemmed from teaching and learning relationships guided by mutual respect and collaboration. For Louise, students, instructors, and unit staff are like members of a team where "everybody's still learning. But you get to the point where you feel you're collaborating, you feel like you're part of the team. That what we're doing is important." Louise acknowledged that FA helps students gain confidence in their abilities: "You feel like you are a part of the team instead of just a lowly student." Similar to her peers who volunteered to be co-researchers, Louise alluded to an underlying level of stress associated with clinical courses; however, she believed that FA contributed to alleviating her fear of failing and enhanced her learning experience as she was more apt to share

personal feelings and ideas in FA situations. She said, "our instructors are watching which is also kind of nerve racking, I've not never once gone through and go, oh my god, I'm gonna fail clinical." Louise explained how she related to instructors in a climate of FA, stating that "if you know you're not gonna fail a test, you can kind of bounce your ideas off them." When FA was used in the clinical setting, Louise felt that "they're giving you the opportunity to go on so you can figure what went wrong." She further elaborated on the instructors' role by saying,

> They're there to let you know like no, those were interesting thoughts but I think you're going off in the wrong direction, have you thought of going this way.

Then from that starting point, they help you if you're going down the wrong trail. Louise found she learned greatly from meetings with her instructors: "You're taking your experiences and you bring them back to the instructor, it's almost verbal reflections, constantly going on and they're really helpful."

Louise recognized the ever-changing nature of nursing knowledge and the need to be a lifelong learner: "You're still learning but I've worked with some nurses when I was working at the hospital last summer and they're still learning many, many years into it." Nevertheless, Louise felt that as one progressed in the nursing program, confidence is gained "and you start to feel like in the end, you're actually going to graduate as a nurse. As opposed to, am I going to be the small fish forever and just not know what I'm doing."

Miranda's negative conception of summative assessment encompassed all types of SA and was amplified by her belief that it contributed to the power differential she perceived as pervasive to the student–instructor relationship in clinical settings. On the

other hand, she believed that FA contributed to shared power and less subjectivity in the assessment process. Recognizing the potential presence of a power dynamic between the instructor and students, Venita used the term superior to acknowledge her respect for the knowledge of her teachers

> I think it's important that we learn that we can trust our superiors so if something happens on the floor or your personal life, you can go to your nurse manager. I think having the clinical student–instructor relationship like that now encourages you to pursue it more in the future. For me superior is a respect term and I don't mean it necessarily as in a power dynamic way. There's a little bit of one there of course, but it's more of, I know that they have those skills and abilities and I respect them for it.

Venita felt that "there is a mutual respect and because they know more, I call them my superior or my primary or whatever title that might happen to pop into my head that day. For me it's a respect thing."

This integrative synthesis of the textural and structural meanings and essences embedded in co-researchers' stories illuminates what it was like for the participating students to be assessed in clinical courses and how they perceived that experience.

Trustworthiness and Authenticity of Data

The importance attributed to the issue of rigor in quantitative research is central to qualitative inquiry, although in the naturalistic paradigm, the terms used to address the concept are "trustworthiness" and "accuracy" (Cohen, 2000). Qualitative researchers strive for excellence in research through disciplined processes, careful adherence to

methodological principles, ethical practice, and accurate descriptions of participants' reality (Byrne-Armstrong, Higgs, & Horsfall, 2001). This is demonstrated though trustworthiness and characterized by *credibility, dependability, confirmability, and transferability* of the findings (Byrne-Armstrong et al., 2001; Fain, 2009; Munhall, 2012; Streubert & Carpenter, 2011). Credibility is attained through activities that increase the possibility of producing credible findings or phenomenological descriptions, and dependability is met once credibility of the findings has been established (Streubert & Carpenter, 2011).

Member checking during the research process is considered a key strategy for establishing trustworthiness (Guba & Lincoln, 1989; Hays & Singh, 2012); however, Maggs-Rapport (2001) explained that it does not serve this purpose for descriptive phenomenology. Interestingly, both Hays and Singh (2012) and Morse, Barrett, Mayan, Olson, and Spiers (2002) explained that it is not appropriate to use member checking to review or confirm findings at the end of a phenomenological inquiry since "study results have been synthesized, decontextualized, and abstracted from (and across) individual participants, so there is no reason for individuals to be able to recognize themselves or their particular experiences (Morse et al., 2002, p. 16). Nevertheless, as suggested by Moustakas (1994), participants were given the opportunity to review their interview transcripts and were encouraged to add any information that they felt would enhance their accounts of their lived experience. Five participants responded to the call for feedback and concurred with the transcribed narratives, two participants did not respond, and one transcript was returned to sender due to participant's change of address.

Moustakas's approach to phenomenological research requires dynamic engagement with the data and consistent use of *Epoche* to ensure that the researcher remain "unencumbered by the assumptions of the natural attitude" (Stewart & Mickunas, 1990, p. 7); this is another means of ensuring credibility in qualitative inquiry. Moustakas (1994) viewed the transcendental phenomenological text as a way of providing "an understanding of what is, in seeing the conditions through which what is comes to be, and in utilizing a process that in its very application opens possibilities for awareness, knowledge, and action" (p. 175). Likewise, van Manen (1990) explained that "a phenomenological text succeeds when it lets us see that which shines through, that which tends to hide itself" (p. 130). As suggested by Moustakas (1988, 1994), I used *Epoche* throughout every step of the research process from the beginning of the first interview and through continuous reflecting, writing, editing, and rewriting until the emerging phenomenon was uncovered and described.

According to Streubert and Carpenter (2011), confirmability is a process criterion that can be established by providing an audit trail or procedural trail of the entire research activities. All documentation related to the research process, including journal entries, interview transcripts, digital audiotapes, and written notes made during and after each individual interview, were used for the duration of the study. Since my reflective diary was an integral component of the research process, relevant evidence from the diary is integrated in the following chapter.

While phenomenological research aims to uncover the essence of particular phenomena, it is not intended as a general description of how similar experiences are lived by other people. Nevertheless, the phenomenon identified should be grounded in

the lived experience of participants and should reflect the universal and the atypical aspects of that experience. Transferability or "fittingness" (Fain, 2009, p. 212) relates to the probability that the findings have meaning to people who have lived similar experiences. van Manen (1990) believed that a good phenomenological description is one that elicits a *phenomenological nod* in its readers: "a good phenomenological description is something that we can nod to, recognising it as an experience that we have had or that we could have" (p. 27). The purpose of this study was to uncover and describe the phenomenon of being assessed in clinical courses from the perspective of nursing students. In the context of this research, transferability will be determined by the readers of my phenomenological description of what it is like for nursing students to be assessed when FA is formally embedded in clinical course.

Ethical Considerations

"Because the objects of inquiry in interviewing are humans, extreme care must be taken to avoid any harm to them" (Fontana & Frey, 2005, p. 715). This research was conducted following the guidelines of the Tri-Council Policy Statement (TCPS) on *Ethical Conduct for Research Involving Humans* (Canadian Institute of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2010). Protocols included obtaining informed consents from participants, highlighting potential risks associated with participation (none in this case), and communicating the voluntary nature of the participation and the opportunity to withdraw at any time without any penalty. As the researcher, I remained respectful and considerate of participants at all times. Since my role as a nursing instructor could have been construed as a position of power by participants, I consistently

assured them that I was conducting this inquiry as a doctoral student from Brock University and not as a teacher. Due to the fact that I am currently a full-time faculty member in the Faculty of Nursing at the university chosen for this inquiry and to minimize the potential of students feeling obligated to participate in the study, only students from sites where I don't teach were recruited to participate in the formal phases of the study. As a faculty member from a different site than the participants, I had no specific knowledge of either the number of potential participants or of the demographic information related to this population.

To ensure clarity of the questions included in the interview guide, third year students enrolled in clinical nursing courses at a site other than the sites chosen for this study were recruited as volunteer participants in the piloting and revision of the guide included in Appendix B. This activity was also done to ensure that questions were formulated in a way that would elicit rich descriptions of experience during the interview process.

Because this study was to be conducted with participants who were nursing students at a specific university, ethical clearance from the Research Ethics Board of that university was sought. The ethical clearance process in the Faculty of Nursing at this particular university involves a two-step process. Hence, a Tri-Council Ethics Application was completed and submitted to the Nursing Ethics Committee. Once they granted the application, it was then forwarded to the University Research Ethics Board along with the signed certificate from the Nursing Ethics Committee. Ethics clearance from the university was received on February 28th, 2013. As a doctoral student of Brock University seeking clearance to conduct research involving human participants, I also

submitted an application to the Social Science Research Ethics Board at Brock University and received ethics clearance on March 18th, 2013 (File # 12-225 – ENGEMANN).

Protection of privacy is of utmost importance and research guided by the TCPS must ensure that participants' information remains confidential throughout the study and beyond. In the context of this study, an informed consent form was developed and used at the beginning of the study. Included in this consent form was basic information about the study and details about the data collection approaches, namely, one semistructured audiotaped interview. Information about confidentiality, risks, and benefits of participation; a statement regarding participants' opportunity to withdraw from the study at any time and for any reason without penalty; and my contact information was clearly conveyed in the informed consent form and it was verbally explained at the time of the interview. Participants were informed that research results may be shared in conferences, in scholarly papers, in discussions related to nursing education, and in my dissertation written for Brock University as a partial requirement for the PhD in Educational Studies. They were assured that their names would not be divulged or appear on any written material related to the research. Participants were offered the opportunity to receive a copy of the findings chapter once the dissertation has been successfully defended, and they all requested a copy. To address participants' right to privacy, self-chosen pseudonyms were used to maintain their anonymity and only I had access to information on their identity. A form titled "Participant Dossier" (see Appendix C) was used to facilitate the systematic management of participants' private information. This information remains locked in a filing cabinet in my office and will be destroyed after 7 years. Only my doctoral supervisor and I have accessed the raw data.

The research methodology and data analysis process described in this chapter guided the inquiry into the lived experience of nursing students with FA formally embedded in clinical courses. Details about the essences and meanings of the phenomenon embedded within participants' stories are presented in Chapter Four.

CHAPTER FOUR: PRESENTATION OF FINDINGS

Transcendental phenomenology provides the means of "arriving at an understanding of what is, in seeing the conditions through which what is comes to be, and in utilizing a process that in its very application opens possibilities for awareness, knowledge, and action" (Moustakas, 1994, p. 175). The purpose of this qualitative phenomenological inquiry was to explore the phenomenon of assessment from the perspective of third year nursing students who volunteered to share their stories of being assessed in clinical courses where formative assessment is formally embedded. The question guiding the research asked: How is the phenomenon of assessment experienced by nursing students when FA is formally embedded in clinical courses? This chapter presents the findings that emerged from the data.

The inquiry led to the identification of six universal textural themes or *noema* and four universal structural themes or *noesis*. The noematic themes that illuminated the *whatness* of the participants' experience were (a) *enabled cognitive activity*, (b) *useful feedback*, (c) *freedom to be*, (d) *enhanced focus*, (e) *stress moderator*, and (f) *respectful mentorship*. The noetic themes associated with *how* the phenomenon was experienced were related to *bodyhood*, *temporality*, *spatiality*, and *relationship to others*. The core textural and structural themes included in Table 7 constitute the meanings and essences of the phenomenon embedded within the accounts of co-researchers.

Core Textural Themes

The following six core textural themes or noema were uncovered following the process of phenomenological reduction.

Table 7

Core Textural and Structural Themes

Core textural themes	Core structural themes
Enabled cognitive activity	Bodyhood
Useful feedback	Temporality
Freedom to be	Spatiality
Enhanced focus	Relationship to others
Stress moderator	
Respectful mentorship	

Enabled Cognitive Activity

Many co-researchers' statements were related to the positive impact of FA on the cognitive processes involved in learning. Through continued reflecting and attending to the data, it became evident that the theme cognition and learning comprised many statements related to co-researchers' perceptions of distinct cognitive processes. As the data were explored further, it became clear that students viewed their brain as a machine-like entity where knowledge was located, accessed, and constructed. Hence, co-researchers conceptualized the brain as the mainframe of cognitive processes where learning is constructed, stored, accessed, or used. They viewed knowledge as a moving entity within the brain, and they believed that emotions and the nature of learning environments were major influential factors in their learning.

For the co-researchers, positive emotions associated with FA were viewed as catalysts to effective cognitive processes leading to deep learning. Conversely, negative emotions associated with SA were described as obstacles to accessing, constructing, and using knowledge. Furthermore, students believed that anxiety or emotionally charged situations associated with SA overrode their ability to use current knowledge and to learn. They claimed that feelings such as apprehension and worry about being evaluated in the clinical setting stifled their learning by negatively influencing their ability to construct new knowledge and to practice safely. For example, Ariel believed that assessment influenced her cognitive processes and that she learned best in FA situations. She stated, "When you're nervous, the task you're doing is put on the back burner because all you're thinking about is calm down, this is ridiculous, you need to calm down. So that's in the front of your brain, that's your first priority." Alluding to practicing nursing under

formative conditions, she added "when I'm not nervous, the knowledge is up front so I just go and I do it, like I have been doing it for ever, even if it's my first time."

Because of its perceived stress-producing effect, SA was loathed by the co-researchers as it triggered troublesome physical and psychological symptoms for all. For example, when she perceives that she is assessed summatively, Ariel shared:

> I start sweating behind the knees, and you know and then, I get shaky and then so here I am trying to calm myself down and thinking again wait now, I'm trying to calm myself down but I gotta keep focusing on the task that I'm doing. But it's hard to balance the two things so the knowledge kind of gets put in the back. I mean when you're nervous all you're thinking about is calm down, this is ridiculous! You need to calm down. So that's in the front of your brain, that's your first priority. When you're nervous the task you're doing is put back on the back burner because you're just trying to tell yourself calm. If you don't have that nervousness then the task that you're doing would be on the front burner.

When asked to elaborate further on her experience of FA in clinical courses, Ariel shared the fact that she was less nervous under FA circumstances and that she learned more effectively during those times. She explained, "[you are] definitely more focused when you don't have the nerves getting at you. You're not sweating, you're not shaking. You're just more relaxed." She added, "your body is definitely more relaxed, your facial features and everything would say if you are nervous." Ariel explained her learning in such situation by saying, "you absorb more when you're relaxed and you're not sweating and just actually learn a heck of a lot more that what you can when you're nervous."

Because co-researchers perceived that FA facilitated the brain's cognitive activity and consequently fostered learning, the first core textural theme, *enabled cognitive activity,* was uncovered from the data.

Useful Feedback

Formative feedback surfaced as a significant factor for all co-researchers as demonstrated by the fact that they ascribed many benefits to sharing and receiving feedback. They acknowledged that because feedback revealed their strengths and areas for needed improvement, it resulted in increased self-confidence and motivation to be self-directed. Feedback associated with FA was identified as a key factor in enhancing co-researchers' knowledge, in shaping their practice, and in preparing them for future clinical situations. Lack of feedback resulted in students not knowing their standing in the course and being unsure about how instructors viewed the quality of their clinical performance; thus, they likened the lack of feedback with "being in the dark."

Guided reflections were the common FA strategy formally embedded in the co-learners' clinical courses, and they were used to foster reflective practice. Universally, co-researchers welcomed the feedback associated with these assignments. Because of the formative nature of the guided reflections, most co-researchers admitted to feeling free to be honest, and they admitted to actively engaging with the reflective activity because they knew that it was not graded. Some admitted to spending more time on details and formatting when assignments were graded. Universally, co-researchers deplored the fact that instructors did not always have sufficient time to offer feedback and that it was often given quickly because of the lack of time and instructor demands from other students in

the clinical group. They all wished for more opportunities to share and receive formative feedback.

Recognizing the essentiality of feedback for learning, co-researchers identified instructors, peers, and staff nurses as valuable sources of feedback while in the clinical setting. Because of the underlying belief that clinical courses were evaluative in nature, some co-researchers wondered whether guided reflections were truly formative. Notwithstanding this concern, they valued the formative feedback associated with guided reflections and wished for increased opportunities to share and receive feedback.

Louise shared that the feedback associated with FA was a powerful factor in her learning. She stated,

> The only way you are going to learn is if you get that feedback and it's a progressive thing that you just kind of add, you change things along the way. If you're hearing like oh you know that was good but you could maybe try and do this next time, again it's just adjusting your routine and your skills to find what works best for you and what works best for the patient obviously and that's how you develop those skills and abilities.

Rose explained that the learning she constructed from guided reflections uncovered different perspectives and she believed that it prepared her for future clinical situations. She viewed guided reflections as tools used "to learn from my mistakes or to understand what I did right and be able to apply it to different people and different situations if it were to arise again." Hence, as she gained deeper knowledge from feedback on her guided reflections and on her clinical performance, Rose's nursing practice improved, "I've learned from it and I can apply it later to other patients or to

other experiences that I come in contact with later." This was echoed by Erika: "formative, they're with you doing things and they'll explain things and they do give us a lot of feedback. It's nice to know you're either doing well or just so so. You can kind of keep doing what you're doing or know if it needs to change."

Erika believed that both positive and negative feedback contribute to learning. While explaining that the nature of the feedback she receives influences her learning, Erika emphasized the importance in the manner that feedback is formulated. "It's the way they do it right? You can give negative feedback in a way that doesn't seem negative." She described formative feedback provided in a positive constructive manner as "comforting" and she pointed out that as a result; "it's just easier to learn. Like if I was nervous all the time then I would be focusing on that rather than focusing on what I'm doing."

Guided reflection was one FA strategy embedded in the curriculum, and participants viewed it as a tool to foster learning through reflective practice. While immersed in the data, it became evident that the formative nature of guided reflections and the usefulness of the associated feedback were the most significant factors that made the guided reflections valuable to students. Hence, the second core textural theme, *useful feedback,* was extracted from the data associated with FA.

Freedom to Be

Co-researchers consistently used the term "liberating" to refer to FA in clinical courses. They claimed that FA lessened the level of stress that they encountered during nursing practice and that because it did not involve a grade, FA contributed to reduce their fear of failing and their concern about being judged. They admitted that,

consequently, they felt free to be honest and genuine during written FA situations and were more relaxed and "able to think" under supervised FA conditions. For example, Rose associated grading with evaluation and judgment; she described feeling free of judgment and safe to learn from FA. In clinical courses, Louise preferred FA to SA because "it's more free" and "you don't feel like you're being belittled." Contrary to SA where she associated grading with judgment, Rose described feeling free of judgment and safe to learn during a specific FA situation. "It was just really good just to not have the judgment that could be placed there if circumstances were different and if it was being graded." Alluding to the concept of instructor subjectivity in the assessment process, Rose shared, "sometimes, based on your instructor and how well you get along with them, you could be judged a little more I guess." When FA was used and the perception of being graded was removed from the assessment situation, Rose explained, "it was good that I could just express what I wanted and not have that judgment."

Co-researchers collectively shared that FA promoted active engagement in learning and fostered deeper learning because of its empowering quality. They believed that their nursing practice and clinical performance were enhanced because of the fact that they were learning under relaxed conditions without worry about grading. They also shared the belief that they found it easier to integrate classroom knowledge into clinical practice when they were involved in FA situations. Co-researchers unanimously identified FA as more conducive to learning than SA because it provided a relaxed environment for learning where they could "think clearly" and "be themselves" without concern of personal judgment.

Miranda expressed that formative assessment made her feel safe and that she could be open with her instructor. She appreciated "being able and liberated to talk and not hesitant about what to say, what words to say. It's just more liberating to have formative." She felt that with FA, "you can actually speak your mind … it's not summative, it's not graded, you're not sitting there getting graded on your opinion or your view. You're able to say something and you don't get penalized." Miranda wished that assessment strategies used in clinical courses "should be more formative, less summative because then we feel a little bit more adept to wanting to share our emotions, our feelings about what's going on."

A common thread inherent within the data alluded to the fact that FA fostered genuine engagement with self-directed learning, lessened stress associated with performance in the clinical setting, and consequently decreased students' concerns about being judged. Co-researchers associated the freedom to be real and the freedom to be honest with FA in clinical courses. For example, Miranda admitted that if FA were more widely used, "there would be more people being able to say how they feel about situations and not be afraid, like they are now." She felt that FA fosters the sense of "being able to say the truth."

Unfortunately, many co-researchers believed that SA triggered the compulsion to deceive and to hide true abilities in order to succeed in clinical courses. Furthermore, some co-researchers suggested that SA might compel students to falsify written accounts by embellishing them because of their fear of failing assignments or clinical courses. This issue warrants further research, as issues of academic dishonesty continue to grow in many educational settings (Neufeld & Dianda, 2007; Whitley & Keith-Spiegel, 2012).

Reflecting on a situation where some of her personal reflection was used for summative purposes, Miranda wondered whether she had been penalized for being honest.

> So it's great that I got to reflect on it, and she said it was a good reflection, but then she used it in [name of specific summative assignment]. So I could have ended up, who knows, failing that term in clinical because of that honesty!

Considering the negative impact of her honesty, Miranda mused,

> If I hadn't reflected on it or if I hadn't even brought it up … she wouldn't have known but I used it in my reflection, and I used it a little bit in that [name of specific summative assignment], and she said due to this happening, needs development.

Although Miranda recognized that "there is a reason for summative because you can't get away from it I don't think. In any job, you get performance appraisals." She admitted

> I'm not a fan of; I never have been a fan of summative umm. I don't think it gets the job done. It is a smoke and mirrors. If you're a great writer, you're going to pass your summative apparently, 'cause well that's been shown quite often in my clinical. Summative [sigh], you're hiding behind a computer typing what you think they want you to say. From my summative experience, I've learned that I suck at writing.

A flagrant example illustrating the potential benefits of integrating more FA in clinical courses was shared by Ariel, who admitted to consciously rushing through nursing care and even staying away from her patients when she knew she was being observed for summative reasons. She stated,

> I'm not the type of person that just walks in and says I'm gonna do this. I talk to patients, I want to know how they're doing, how their day was, and that's why I tend to take a little bit longer [laughing] than what I'm supposed to [laughing].

Sadly, Ariel admitted that when she perceived that instructors were grading her performance, she consciously refrained from spending time at the bedside and hastily completed supervised tasks. Evidence that SA negatively influenced Ariel's relationships with her patients, her nursing practice, and ultimately her learning was further evidenced when she said, "I go in, get the job done type of thing and get the heck out of there because I know I'm getting marked." In a disappointed tone, she noted,

> It's just too bad because I would have liked to have that interaction with the patient on a little bit more of a personal level but I feel like when I'm getting marked, I gotta go in and do everything as fast as possible because I'm getting graded.

Troubled by her behaviour, she wished for more FA in clinical courses so she could practice nursing without the constant fear of clinical failure.

The majority expressed a sense of freedom to be themselves when faced with FA situations. For them, not being graded when assessed by instructors tapered their fear of failing and lessened their apprehension about being judged. Consequently, because co-researchers expressed that they could be candid while sharing personal feelings and emotions, verbally and in writing, during specific learning experiences in clinical courses where FA was used, the third textural theme, *freedom to be,* emerged as fundamental to their experience of assessment.

Enhanced Focus

In all of the interviews, FA was associated with positive statements about the ability to think more clearly during formative situations. Eventually, as the process of thematic clustering continued, the data revealed that students perceived an imaginary wall that stifled students' ability to think in the clinical setting when they perceived that SA may be used. Co-researchers viewed FA as a significant factor in decreasing anxiety and in enhancing one's ability to think and focus. They claimed that feelings such as apprehension and worry about being evaluated in the clinical setting stifled their ability to think clearly and made them more prone to mistakes. Ultimately, co-researchers believed that FA enhanced their cognitive processes because it decreased their stress and consequently lessened their fear of failing clinical courses.

While co-researchers associated SA with evaluation and academic requirements, they viewed FA as a strategy that fostered integration of current knowledge and construction of deeper learning under relaxed and supportive conditions. For example, Venita shared,

> If you do get stressed out about something, you're more anxious and you're more apt to make a mistake. So if you take away that part of the stress, the "Am I gonna get an A, B, or whatever," then you just have the skill or the procedure or the communication technique and that's your focus. So you can narrow in and get rid of all the other distractions that are coming your way.

Reflecting on a situation where she perceived that her performance was assessed summatively, Ariel stated, "knowing if it was a formative assessment, I would have been less nervous. I would have been able to think more clearly." She pondered, "it was just

terrible knowing how nervous I was all shaking and putting your gloves on. Knowing if it was a formative assessment, I would have been less nervous. I would have been able to think more clearly." After further reflection, Ariel indicated that not only the assessment strategy but also the particular instructor's approach influenced her learning. She said, "it would have been better if I knew I wasn't being marked per se and she just said do you want to do this catheter. I would have been whatever."

All co-researchers believed that under FA conditions, their cognitive processes were enhanced and their performance was positively impacted by their ability to focus. Ultimately, they believed that FA facilitated their cognitive processes and allowed them to think clearly. Hence, through mindful engagement with the data, the fourth core textural theme, *enhanced focus,* was uncovered.

Stress Moderator

Co-researchers expressed pervasive feelings of anxiety while practicing in various clinical environments and they attributed it to the responsibility to keep patients safe. Although statements about inherent stress in the clinical setting were common, co-researchers claimed that their level of stress decreased when they knew that their clinical practice was not being graded. They expressed feeling an expected sense of anxiety when they were in the clinical setting; however, they claimed that when they perceived that they were being evaluated, their anxiety intensified and became extreme because they feared they would make mistakes or that they could fail the clinical course. Sadly, when discussing FA, all co-researchers alluded to the fear of failing clinical courses rather than focusing on their desire to be successful in the course.

SA was reviled for its stress producing effect that resulted in uncomfortable symptoms for many. Physical and emotional reactions, such as sweating, shakiness, facial flushing, decreased self-confidence, an inability to focus, and increased anxiety, were some of the symptoms associated with learning under SA conditions. Co-researchers reiterated that because FA decreased their level of anxiety, it enhanced their ability to learn. They perceived that FA contributed to enhanced clinical performance. For example, Ariel's affinity for FA was further evidenced in her following statement: "When I'm doing it formatively, we just walk in me and the instructor, give the injection or the IV or whatever I have to do, and casually walk out. It's just a better experience, more of a relaxed experience." She shared that she learned best with FA because "the formative is definitely the way to go obviously, just from my experience. I really do enjoy the formative. You absorb the learning more; it takes you further for sure. It just enhances my learning."

For co-researchers, FA was viewed as liberating and stress reducing. Because co-researchers repeatedly shared that FA helped maintain a manageable level of anxiety so they could practice safely without the fear of failing, the fifth core textural theme, *stress moderator,* was extracted from the data.

Respectful Mentorship

Instructors' approaches to the scholarship of teaching and learning (SOTL) and the perception of power differentials constituted an important aspect of students' experience of assessment in clinical courses. The supportive nature of the student–instructor relationship was valued, and co-researchers acknowledged that they preferred learning *from* and *with* others such as peers, instructors, and staff under FA conditions.

Co-researchers' use of metaphors provided evidence that the nature of learning in clinical courses encompassed the distinct nature of the student–instructor relationship as well as the characteristics of the learning environments where learning experiences occurred.

Rose found that she learned at a deeper level when respectful student–instructor relationships were involved. She explained, "I would say there's the same amount of learning but if you go through an experience together, I find that it resonates more and I think about it more and it impacts me more." To explain further, Rose added, "if this experience is new for her too, we are learning at the same time so it's OK for both of us to make mistakes and it's just more comfortable." Rose felt that her nursing care was influenced by the people she learned with; "you can better direct your care based on other people's experiences." Erika shared, "I've never had an instructor that I didn't learn with."

For co-researchers, how instructors approached teaching and learning, as well as how they related to students, was key to determining the quality of the clinical experience and the related learning. They also shared their belief that instructors who used FA consistently made them feel motivated to learn and that this resulted in safe student practice and safe patient care. Co-researchers suggested that clinical instructors who were student focused and who used FA consistently contributed to enhanced learning. They claimed that instructors who were not student focused contributed to intensify the power differential between students and instructors in the clinical setting.

Recognizing her own responsibility for learning, Louise explained, "as far as these instructors go, they're not you're your elementary, junior high, or high school teachers. You're an adult and you're just kind of bouncing ideas off them. They're more

of a guide and a mentor." Like other co-researchers, Louise pointed to the collaborative nature of the student–instructor relationship and to the concept of mentoring. She believed that, as she gained confidence in her abilities, her sense of self changed, and she felt like she could contribute to the team that was involved with her clients. She stated that "you kind of feel like you're part of a team because they're the team leader. You're working with them, it's very team oriented." Julia appreciated having her instructor close by as she shared,

> Just having that person there to kind of explain and go through it for the first time, it's good and then knowing that they trust you enough or that you did well enough that they'll let you go and do it by yourself the next time it's nice.

A number of vivid metaphors related to respectful and supportive teaching were embedded in each co-researcher's experience of assessment in clinical courses. Consequently, *respectful mentorship* was uncovered as the sixth core textural theme associated with the phenomenon under study.

Core Structural Themes

The aim of phenomenology is to look at *a priori* textures and structures of experience before any reflecting has been done on it. According to Gallagher and Zahavi (2010) "the notion of pre-reflective self-awareness is related to the idea that experiences have a subjective 'feel' to them, a certain (phenomenal) quality of 'what it is like' or what it 'feels' like to have them" (p. 3). Through the process of imaginary variation, the data were explored for evidence of common a priori structures embedded in the co-researchers' accounts that would illustrate how the phenomenon was experienced

prereflectively. The following four common core structural themes or *noesis* were embedded within participants' stories.

Bodyhood

The first core structural theme, bodyhood, relates to internal processes of the body as well as to one's relationship with it. In the context of this study, bodyhood encompassed statements related to cognitive processes as well as physical and emotional reactions to stress. A number of physical symptoms were experienced by co-researchers when they perceived being assessed summatively during clinical experiences as they claimed that stress derived from SA was the most significant barrier to their learning. They shared similar accounts of distressing symptoms such as sweating, shakiness, facial flushing, decreased self-confidence, an inability to focus, and anxiety that intensified when they knew they were assessed summatively or when the fear of clinical failure arose. They unanimously believed that such symptoms impacted their cognitive processes and hindered their ability to learn.

For example, Ariel shared having strong physical reactions to stress associated with learning in uncommon situations or in summative assessment contexts:

> I'm one of these people that if I know I'm being marked; my nerves, I can feel myself. My face goes red when I'm worked up. My face goes red which adds to my anxiety and my nervousness because the patient sees that, then that makes it even worse.

She continued:

> When I blush and I know people are staring at me, I blush even more and then I start sweating behind the knees. It really is physical for me and the whole time

> I'm trying to calm myself down, I know these two people are staring at me. So it is a lot of physical for me.

Holly also expressed experiencing distinct physical symptoms when being assessed in summative situations and described them as "like a knot in your stomach," "it's just unsettled." She added "you just feel like your body tensing up and it just doesn't feel good."

Temporality

The second core structural theme, temporality, was evident in the many references to time embedded in co-researchers' stories. For example, Venita condemned the lack of time available to discuss guided reflections. She explained,

> There is a real lack of time. Let's just put it that way, when it does happen, it happens on a quick, fast basis. When they do have time, it is given, it's given on the fly, in the hallways or in the classrooms. In their offices when we have time to do our reflections, we talk over them.

Statements associated with time constraints related to the tedious nature of writing guided reflections and with instructors' lack of time to discuss and provide feedback in the clinical setting were aggregated under the structure of temporality.

Spatiality

Spatiality was the third core structural theme embedded in the data. It referred to one's perception of physical and emotional space. In the context of this inquiry, spatiality was evidenced in a significant number of statements comparing classroom and clinical courses. The distinct conceptualization of classroom-based courses as theoretically focused academic courses and of clinical courses as mostly practical in

nature was common. For example, zoning in on the practical aspect of clinical courses, Julia stated:

> I never feel frightened that I wouldn't pass a clinical course. Finally getting in there and seeing what it's like to actually be an RN or working in a hospital; something like that I get excited about and I really don't think that much about the grade aspect of it. I don't really think of it as a course as much.

Similarly, co-researchers shared the perception that content learning occurred in classroom courses and that clinical courses were mere settings where real-life experiences were provided and where nursing practice was evaluated.

Co-researchers did not perceive clinical courses to be spaces where learning was constructed, and some admitted that they did not consider them to be courses in the academic sense of the word. While they associated the concepts of memorization and testing with classroom-based theory courses, co-researchers related the tasks of "showing what you know" and "performing skills" to clinical courses. Consequently, they did not question the use of SA in classroom-based courses but suggested that FA was more suitable for clinical courses. Unanimously, they wished for a more pervasive use of FA in clinical courses.

Relationship to Others

The fourth and last core structural theme, relationship to others, was universal to participants' stories and it comprised statements about their perception of student–instructor relationships as well as instructors' approach to the SOTL. Clinical instructors were viewed as facilitators of learning. For example, Louise used the metaphors of the

guide and mentor to illustrate her conception of the student–instructor relationship and she believed that instructors and students shared a common goal:

> The instructors are not there to beat up on us, they're not there to hammer things at you like this, this, this, this and this. They are all fully willing to let you know that there are different ways to get to the same results and just because one instructor says do it this way, and I'm doing it this way, find what's more comfortable for you. So long as you're still following the precaution guideline or the sterile technique or whatever, they're there less as a dominance thing and more as a guide.

She acknowledged the instructors' willingness to share their individual knowledge and to mentor students as they learn to become nurses.

Because of the supplementary roles of guiding and supporting learning, instructors were deemed the most influential persons in the students' learning experience. For co-researchers, how instructors approached teaching and learning as well as how they related to students, were key to determining the quality of the clinical experience and the related learning. They also shared their belief that instructors who used FA consistently made them feel motivated to learn and that this resulted in safe student practice and safe patient care. Co-researchers suggested that clinical instructors who were student focused and who used FA consistently contributed to enhanced learning. They claimed that instructors who were not student focused contributed to intensify the power differential between students and instructors in the clinical setting.

This chapter presented the meanings and essences of the lived experience of nursing students with assessment when FA is formally embedded in clinical nursing

courses. The next chapter presents the research findings in relation to the literature, limitations of the research, and implications for future research.

CHAPTER FIVE: DISCUSSION AND CONCLUSIONS

This qualitative inquiry focused on the phenomenon of assessment in clinical nursing courses. Through an integrative review of both the nursing and education literature, a gap related to the knowledge of the phenomenon of assessment in clinical nursing courses was identified. While research on SA in clinical nursing courses was abundant, research on FA in nursing education remains scarce and it is focused mainly on classroom-based courses. Because no similar research was found in the literature, it was determined that uncovering nursing students' experience of being assessed in clinical courses where FA was formally embedded addressed a significant gap in the nursing education literature. Using transcendental phenomenology as the research methodology, semistructured interviews were conducted with eight nursing students to address the research question: How is the phenomenon of assessment experienced by nursing students when FA is formally embedded in clinical courses?

The essence and meanings of the phenomenon inherent within the data were uncovered after concentrated periods of in-depth reflective and imaginative activities guided by the systematic approach outlined in the "Modification of the Van Kaam Method of Analysis of Phenomenological Data" (Moustakas, 1994, pp. 120–121). As a descriptive qualitative research, this inquiry highlighted what the phenomenon of assessment was for the nursing students who volunteered to share their stories and how they experienced it. In this chapter, the findings are discussed in relation to the literature, the limitations of the study as identified, and implications for future research are presented.

Relating Findings to the Literature

As explained in Chapter Two, an integrative review of the literature was conducted before developing the research proposal for this inquiry, and secondary review was done following data analysis for the purpose of correlating the literature with the findings of the inquiry. The second review spanning the 15-year period between 2000 and 2015 included the databases: CINAHL, ProQuest, ERIC-EBSCO, Google Scholar, and SSCI which were searched using a combination of the following key terms: *clinical nursing education*, *formative assessment*, *feedback*, *cognition*, and *stress*. This search yielded over 20 research articles and one dissertation thesis. Of those, nine qualitative research articles were deemed pertinent as they addressed the influence of formative feedback on learning. Because of the scarcity of literature on FA in clinical nursing education, a considerable number of e-books and books in print were used to assess the state of the knowledge of FA in nursing education and to correlate the findings.

Enabled Cognitive Activity

Co-researchers' conceptualization of the brain as the mainframe of cognitive processes is congruent with the education literature on cognition, which abounds with theoretical and scientific information about the cognitive abilities of the human brain. The intricacy of the brain and its role in learning continue to be the subject of intense research and, to date, many models have been developed to explain the dynamic interactive processes involved in learning (Glick, 2011; Jensen, 2008; Matlin, 2009; Sousa, 2011). The complexity of cognitive processes at the neuroscience level is beyond the realm of this dissertation; however, because co-researchers perceived their brain to be the area where information was processed and where knowledge was constructed, the

information processing model by Sousa (2011) is used here to correlate various findings embedded in the data.

The information processing model by Sousa (2011) underwent many revisions since it was first developed. Adapted from an earlier model developed by Robert Stahl, whose cognitive processing model reflected the neuroscience research of the 1960s and 1970s, Sousa's most recent revisions reflect the current research on cognition. Although many information processing models compare the brain to a computer, Sousa is quick to point out that such an analogy is problematic because computers do not have the mental capacity that the human brain has and the computer's only means of communication remains the binary code. To explain and support his conceptualization of the information processing model, Sousa referred to the brain as "an open, parallel-processing system continually interacting with the physical and social worlds outside. It analyses, integrates, and synthesizes information and abstracts generalities from it. Each neuron is alive and altered by its experience and its environment" (p. 44).

The conceptualization of knowledge as a moving entity within the brain is commonly used in the neuroscience literature, especially in the instructional theory literature (Erlauer, 2003; Glick, 2011; Jensen, 2008). Sousa (2011) proposed a simplified model to explain the complex process of how the brain deals with information. The information processing model included in Appendix D is comprised of common day-to-day objects such as a clipboard, a table, and filing cabinets with arrows pointing to different directions where information is collected, analyzed, stored, and accessed. Sousa claimed that his model "limits its scope to the major cerebral operations that deal with the collecting, evaluating, storing, and retrieving of information – the parts most useful to

educators" (p. 42) and he used arrows and common objects to illustrate the various processes involved in learning.

The fact that co-researchers viewed positive emotions associated with FA as catalysts to effective cognitive processes leading to deep learning is congruent with the literature on cognition. The brain is a complex organ composed of two hemispheres that are further demarcated into lobes (Glick, 2011; Jensen, 2008). Each hemisphere and its lobes are responsible for different functions. For example, while the frontal lobes are considered the hub of critical thinking, problem solving, and creativity, the temporal lobes are the focal point where language, auditory processing, and memory happen (Glick, 2011; Jensen, 2008; Matlin, 2009). The amygdala and the hippocampus are two interrelated structures associated with learning. They are situated deep in the brain, an area called the limbic region. While Glick (2011) credited the hippocampus for the ability to form memories, she likened the amygdala to "an emotional soldier, guarding the brain's gate" (p. 22). She suggested that during positive emotional experiences, the brain releases chemicals that contribute to motivation, happiness, and enhanced cognitive processes. For Glick, a positive emotional environment fosters learning by enabling the cognitive processes to function effectively. Similarly, Sousa (2011) acknowledged the significant influence of emotions on learning, and he claimed that feelings are fundamental factors in the amount of attention students commit to learning. It is therefore not surprising that because co-researchers perceived FA to be a contributing factor to relaxed and conducive learning environments, they preferred to be assessed formatively when performing in clinical environments and perceived that their cognitive processes were enabled rather than hindered.

The impact of emotions on the limbic system is evident in the literature (Glick, 2011; Jensen, 2008; Matlin, 2009; Sousa, 2011). While they viewed positive emotions as catalysts for learning, co-researchers described negative emotions as obstacles to accessing, constructing, and using knowledge. They claimed that anxiety or emotionally charged situations such as those associated with SA conditions impeded their ability to learn. Interestingly, a review of the education literature on cognition confirmed this distinct perception of co-researchers as accurate. For example, Glick (2011) stated, "when someone experiences highly negative events, areas of the brain that are in charge of critical and creative thinking shut down, resulting in survival responses" (p. 43). Similarly, Sousa (2011) acknowledged the role of the limbic system, especially the amygdala and the hippocampus, in facilitating or suspending complex cerebral processes. He claimed that stress hormones resulting from negative emotions can affect the hippocampus and, consequently, restrict and even stop cognitive functions. Sousa suggested, "the reflective override of conscious thought can be strong enough to cause temporary inability to talk ("I was dumbfounded") or move ("I froze")" (2011, p. 47). This is congruent with many of the stories shared by co-researchers who felt that when they were anxious, they focused on the cause of their anxiety or the perceived "threat" and had difficulty remembering or accessing the knowledge that they needed to perform a skill or to answer questions. On the other hand, when involved in FA situations, co-researchers admitted that they learned better and could think more clearly.

Co-researchers viewed classroom-based courses as academic courses focused on theoretical content, and they conceptualized clinical courses as predominantly practical in nature. They suggested that SA was more applicable to theory courses and that FA

enhanced their clinical experiences by making the clinical environment more conducive to learning. Consequently, they believed that FA should be used more consistently in clinical courses in order to foster learning and improve practice. It is important to note that although FA and SA have distinct purposes, the benefit of combining FA and SA strategies throughout the teaching and learning process to foster learning and to meet academic requirements is evident in the literature on assessment (Boyle & Charles, 2014; Cizek, 2010; McWilliam & Botwinski, 2010; Wiliam, 2010; Yorke, 2003).

Many authors have debated the benefits of integrating cognitive science into education practices (Glick, 2011; Jensen, 2008; Schank, 2011; Sousa, 2011). The dynamic advancements of neuroscience have provided educators with new knowledge about teaching methods and strategies that are aligned with cognitive processes to enhance learning (Glick, 2011; Jensen, 2008; Schank, 2011; Sousa, 2011). In the context of this literature review, an increasing amount of literature based on brain research was found. Concepts such as *brain-compatible activities* (Glick, 2011, Sousa, 2011), *brain-based learning* (Jensen, 2008), and *cognitive processes-based education* (Shank, 2011) were linked with significant improvement to the teaching–learning process, specifically with the enhancement of specific skills such as critical thinking, problem solving, and self-regulation. As stated by Erlauer (2003), "educators working in brain-compatible environments can develop an unprecedented professional competence that will enable students to reap the rewards of powerful, successful learning" (p. 2). Literature on cognitive science and clinical nursing education remains scarce. From this inquiry, new understandings about the growing body of knowledge called "educational neuroscience" (Sousa, 2010, p. 1) point to the potential value of integrating cognitive science theory into

nursing education. The findings of this inquiry suggest that a deliberate consideration of current cognitive theory may provide nurse educators with insight into the effectiveness of specific brain-compatible teaching strategies, and, consequently, move nursing education forward into the 21st century. More on this point will be discussed later in this chapter.

Useful Feedback

Formative feedback associated with FA was identified as a major influential factor by all co-researchers as they praised its informative nature and its impact on shaping their nursing practice. For co-researchers, a lack of feedback resulted in uncertainty and increased anxiety about their ability to progress in clinical courses and, ultimately, in their nursing program. Being aware of their standing in the course, as well as their strengths and areas of needed development, was viewed as the ideal conditions for learning in clinical courses. The amount of literature on feedback was significant and pointed to its critical importance in the teaching–learning process. For example, Tee and Ahmed (2014) defined feedback as "the crux of a learning process" (p. 579), whereas Pollock (2012) viewed feedback as "the hinge factor for improving student learning" (p. 3). Evidently, the co-researchers' appreciation and wish for more feedback pointed to its critical influence on learning, which was reflective of the current literature on cognition and SOTL. Acknowledging the value of feedback for the teaching and learning process, Li and De Luca (2014) agreed that "effective formative feedback links closely to improved student learning" (p. 378).

Co-researchers identified instructors, peers, and staff nurses as valuable sources of feedback. While the literature pointed to the pedagogical value of self-assessment, it also

alluded to the benefits of getting feedback from various sources. For example, Tee and Ahmed (2014) proposed an integrative framework where self-assessment as well as feedback from peers and teachers are integrated to enhance learning. The *360 degree feedback system* is guided by the authors' belief that students' engagement with learning "is influenced by individual and contextual factors, such as relationships between students, peers and teachers" (Tee & Ahmed, 2014, p. 583). One source of literature reflecting the impact of staff nurses on nursing students was provided by Benner et al. (2010), who claimed that, although relationships between staff nurses and students are not always focused on student learning, "staff nurses are essential to the clinical education of student nurses" (p. 61) and they are ultimately responsible for the patients assigned to students. The value of feedback associated with FA for enhancing the SOTL is undisputed in the literature, and this inquiry points to its benefits for clinical nursing education.

Freedom to Be

Reflective activities such as guided reflections were the common FA assignment embedded in the clinical courses of the co-researchers; however, clinical instructors were free to integrate other FA strategies into their clinical teaching. Students admitted to feeling more engaged when FA was used. Koh (2008) conducted a literature review to explore the benefits of FA in classroom-based nursing courses. She found that the use of FA was associated with the development of self-regulation skills and resulted in increased involvement of nursing students in their learning. Koh further claimed that reflective assignments used formatively to assess one's own learning from specific experiences promoted self-regulation in students as they engaged in the assessment

process. As reminded by Wylie, Reschly, and Wylie (2012), reflective assignments that are part of FA practices empower students to learn and contribute to increased engagement with learning. In this inquiry, co-researchers reiterated their perception that FA fostered positive learning environments free from the fear of grading and personal judgment. Oermann (2015) suggested that students tend to be more engaged with learning when the learning environment is positive; conversely, she posited that students are more likely to withdraw from learning when the environment is viewed as punitive or not conducive to learning. Earl (2013) maintained:

> Assessment can enhance student motivation by emphasizing progress and achievement rather than failure, providing feedback to move learning forward, reinforcing the idea that students have control over and responsibility for their learning, building confidence in students so they can and need to take risks. (p. 78)

This is congruent with the findings and the spirit of the stories shared by co-researchers. According to Greenstein (2010), FA contributes to preparing the mind to learn and it supports the brain's cognitive abilities. In light of this study into the phenomenon of assessment, a fresh look at assessment practices in clinical nursing education guided by the new understandings about the brain and its role in learning may be warranted, as it may address some of the issues experienced by co-researchers.

Enhanced Focus

Co-researchers viewed FA as conducive to learning, and they shared their perception of SA as punitive, stressful, and a significant barrier to learning in clinical courses. They shared the belief that knowing they were being assessed summatively

prompted them to rush through performance at times and that it contributed to mistakes that they would not have made if the fear of grading were removed, such as with FA. Blakemore and Frith (2005) claimed that "stress, anxiety, and fear in the classroom can impair the capacity to learn by reducing the ability to pay attention to the task at hand" (p. 179). It is important to recognize that because the main purpose of clinical education is to foster the construction of nursing knowledge and to socialize students to the professional role of nurses; the emphasis of clinical courses should be on student learning rather than grading. Therefore, the main part of clinical courses should revolve around constructing nursing knowledge and improving nursing practice. This study suggests that integrating FA in clinical nursing courses enhances learning conditions and fosters the construction of nursing knowledge. It also suggests that evaluation periods should be predetermined and communicated to learners because "students need to engage in learning activities and practice skills before their performance is evaluated summatively" (Gaberson et al., 2015, p. 16).

Although the process of assessment and CPA should foster opportunities for students to grow as future nurses and for knowledge to be constructed or deepened, nursing students are aware that clinical instructors observe and collect data throughout clinical experiences and that these data collected over time may be used to attribute a final grade in the course (Del Prato, 2010; DeYoung, 2009; Gaberson et al., 2015; McCutchan, 2010; Wiles & Bishop, 2001). As a consequence of this practice by nurse educators, the pedagogical value of the teaching and learning process in clinical courses may be weakened and the potential of FA may be negated by students' perception of clinical experiences as stressful and evaluative in nature. Repeatedly, studies have shown

that nursing students often perceive CPA to be punitive (Del Prato, 2010; Gaberson et al., 2015; McCutchan, 2010; Wiles & Bishop, 2001) rather than a means to document strengths and areas for improvement in clinical practice. Referring to CPA, McCutchan (2010) explained that "students have not always sensed the evaluation process to be a learning opportunity that accurately reflects their performance, but rather view it as a punitive experience" (p. 9). As evidenced in the nursing literature, the clinical performance of nursing students is assessed while they are still in the process of integrating classroom knowledge to the clinical area and while they construct new knowledge from the various experiences that they encounter (McCutchan, 2010; Reilly & Oermann, 1999; While, 1991). Gaberson et al. (2015) confirmed that this practice continues to be perpetuated: " Nursing faculty seem to expect students to perform skills completely the first time they attempt them, and they often keep detailed records of students' failures and shortcomings, which are later consulted when determining grades" (p. 10). Thus, even today, clinical course grades are predominantly the result of observations of clinical performance conducted while students learn to provide care for different clients and while interacting with various health care workers within different clinical settings (DeYoung, 2009; Gaberson et al., 2015; Stuart, 2007).

The following analogy of the road test required for obtaining a driver's license illustrates the inadequacy of evaluating students as they learn and supports the practice of integrating more FA into clinical nursing courses:

> What if, before getting your driver's license, you received a grade every time you sat behind the wheel to practice driving? What if your final grade for the driving test was the average of all of the grades you received while practicing?

> Because of the initial low grades you received during the process of learning to drive, your final grade would not accurately reflect your ability to drive a car. (Garrison & Ehringhaus, n. d., p. 2)

The final driving test, or SA, should be the accountability measure that establishes whether you have the driving skills necessary for a driver's license and not a reflection of all the driving practice that leads to it. This analogy helps understand the pedagogical nightmare of the current CPA practice and why the level of stress associated with clinical courses is much higher than classroom-based courses (Billings & Halstead, 2012; DeBrew & Lewallen, 2014; Stuart, 2007). The literature indicates that the potential of FA for informing learning is significant. Duers and Brown (2009) agreed, as they noted that in addition to preparing nursing students to function outside educational environments and in the real world, formative assessment also helps prepare students to succeed in summative assessments.

Stress Moderator

The pervasive sense of anxiety perceived by co-researchers when in clinical settings is not uncommon. In fact, literature about the stress perceived by nursing students when in clinical settings is extensive (Billings & Halstead, 2012; DeBrew & Lewallen, 2014; Oermann, 2015; Oermann & Gaberson, 2014). Melo et al. (2010) used a descriptive, comparative design to explore the many factors contributing to clinical practice anxiety in nursing students. They identified observation and evaluation of students' performance as the most anxiety-provoking aspects of clinical practice experiences. Interestingly, in her study of nursing students' experience with CPA, Reynolds (2005) found that "the process of simultaneously learning and being evaluated

can be very frightening and intimidating, especially during the earlier semesters when students are still struggling with a deficit of knowledge and tremendous anxiety" (p. 129). She expressed concern about the issue and condemned the process of evaluating nursing students as soon as they enter the clinical setting.

Co-researchers indicated that they were more engaged with their learning, more focused in their thinking, and that they learned at a deeper level when assessed formatively. Conversely, they shared feeling an increased stress level and even debilitating physical symptoms when they perceived that their performance might be observed for summative purposes. This is consistent with the literature discussed earlier regarding the effect of stress on the limbic system. Most pathophysiology literature suggested that when stress is experienced, reactions such as cognitive disturbance, uncomfortable physical symptoms, and distinct emotional responses can result (Hannon, Pooler, & Porth, 2010). The characteristics and intensity of the reactions are unique to each person; however, the literature clearly showed that although stress can be beneficial in some situations, it can have detrimental effects on cognition and may even contribute to several diseases or health challenges (Hannon et al., 2010; McCance, Huether, Brashers, & Rote, 2014). The fact that co-researchers experienced various levels of physical and emotional symptoms from the stress that they associated with SA situations is congruent with the literature on stress and cognition. McCance et al. (2014) proposed that "psychologic stressors can elicit reactive or anticipatory stress responses" (p. 339) and explained that even "the stress of an examination may produce an increased heart rate and dry mouth in the unprepared student" (p. 341). Combined with the cognitive science literature discussed earlier, this supports the findings that when co-researchers perceived

stress associated with observation for summative purposes, their physical symptoms were a natural physiological reaction to stress, and there is a strong possibility that their learning may have been hindered as a result. Reviewing the literature on the effect of stress on learning revealed startling information about the extent of its effects not only on the brain but on the whole body. Being a student was consistently linked with high levels of stress and potentially compromised health. For example, Hannon et al. (2010) shared the idea that in addition to making students more prone to illnesses such as colds and flu, oral disease such as canker sores are common during periods of high stress such as exams. Besides increasing susceptibility to viral infections, stress is a significant factor in learning (Billings & Halstead, 2012; DeBrew & Lewallen, 2014; Hannon et al., 2010; Oermann, 2015; Oermann & Gaberson, 2014).

According to Yorke (2003), when students are concerned with grades, "the effect can be hostile to effective learning" (p. 482). Findings from this inquiry suggest that because FA is associated with conducive and supportive learning environments, an increase in the integration of FA in clinical nursing courses may help to moderate the level of stress experienced by students and may consequently foster learning within clinical environments.

Respectful Mentorship

Respectful mentorship was a predominant theme embedded in the stories of co-researchers who acknowledged learning with and from others, such as peers, instructors, and staff who worked in the clinical environments where they practiced. Respectful mentorship also encompassed the distinct nature of the student–instructor relationship as well as the nature of the learning environments where learning experiences occurred.

However, the most influential aspects of respectful mentorship discussed by co-learners were the student–instructor relationships and the instructors' approach to the SOTL which were viewed as important influential aspects of learning. Words such as facilitator, guide, and crutch are examples of terms used by participants to describe the distinct role of clinical instructors. Vivid metaphors such as mamma bear and mother hen were also used to describe the intimate supportive nature of the relationship between nurse educators and nursing students in clinical courses.

An abundant amount of literature on nursing education contained information about the unique nature of the student–instructor relationships as well as the role of clinical instructors that substantiated co-researchers' experience of assessment in clinical courses. For example, Gaberson et al. (2015) and Billings and Halstead (2012) pointed to the complexity of the interactions between nursing students and their clinical instructors, recognizing that multiple factors influence the quality of this relationship. The list of responsibilities associated with teaching nursing is exhaustive and contributes to the nature of the student–instructor relationship. While the role of clinical teachers may include responsibilities such as facilitating learning and supporting students' socialization process, they are also considered the gatekeepers of the profession (DeBrew & Lewallen, 2014; McIntyre & McDonald, 2014; Ross-Kerr & Wood, 2011).

While nurse educators' responsibilities associated with SOTL remain critical to the education of future nurses (Billings & Halstead, 2012; Gaberson et al., 2015; McIntyre & McDonald, 2014; Ross-Kerr & Wood, 2011), conflict between faculty and students was identified in the literature as an influential factor in students' engagement in learning. Hossein et al. (2010) conducted a qualitative study of teachers' experiences

with clinical teaching and noted that collaboration between teachers and students is an essential element of the learning experience in clinical nursing courses. In a quantitative survey of nine Western European countries, Warne et al. (2010) found that although different structures, standards, and approaches to nursing education were in place, the 1,903 nursing students who participated in the study unanimously identified "ontological security" (p. 809) as the most important characteristic of clinical environments. For these students, a culture of collaboration and tolerance leading to an environment where they felt safe to make mistakes as part of their learning was viewed as a quality-learning environment that promotes ontological security. A common belief amongst co-researchers was that FA rendered the clinical environment more conducive to learning and that student–instructor relationships guided by mutual respect moderated the power differential and contributed to enhanced learning. In the context of this inquiry, the perceptions of an effective student–instructor relationship paralleled information found in the literature.

The potential for learning from FA practices and from student–instructor relationships guided by mutual respect and trust was evident in the literature. FA and effective student–instructor relationships were boasted as key contributing factors for student engagement and enhanced learning (Boyle & Charles, 2014; Earl, 2013; Oermann, 2015; Stuart, 2007; Wiliam, 2011a, 2011b; Young & Maxwell, 2007). As reminded by Oermann and Gaberson (2014), "effective teachers treat students fairly and create an environment of mutual respect between educator and student" (p. 377); such environments are particularly conducive to learning (Boyle & Charles, 2014; Earl, 2013; Oermann, 2015; Stuart, 2007; Wiliam, 2011a, 2011b; Young & Maxwell, 2007). This

study's results point to the essential nature of collaborative teaching–learning relationships between nursing students and their clinical teachers as well as to the benefits of using FA during teaching and learning encounters in clinical courses.

Limitations of the Research

Several limitations of the inquiry should be noted. First, all of the co-researchers who volunteered to participate in the study were female nursing students who were in their third year of study, thereby offering insight from a unidimensional perspective. Despite the fact that male nurses are a minority in most Canadian nursing programs (Billings & Halstead, 2012; McIntyre & McDonald, 2014; Ross-Kerr & Wood, 2011), their perspective is important in uncovering phenomena related to nursing students' experience. Furthermore, studying the experience of students who are at different levels in their nursing program may also offer insight into the phenomenon.

Second, in the context of this inquiry, only the perspective of students was explored. Because clinical instructors are unique partners in the learning experience of nursing students, research into their unique experience of assessment may bring to light different aspects of the phenomenon.

An issue that warrants mentioning in this section relates to the time taken for data analysis. Unfortunately, the process of data analysis was interrupted as I struggled to come to terms with the untimely death of my husband. Although time away from the research process may be perceived as a limitation, Moustakas (1994) claimed that each approach to human science is open-ended in nature and that "each research project holds its own integrity and establishes its own methods and procedures to facilitate the flow of the investigation and the collection of data" (p. 104). Similarly, van Manen (2014)

maintained "at every turn of the inquiry process there is an implicit reliance of the taking on of a phenomenological attitude, requiring heuristic attentiveness, creative insight, interpretive sensibility, linguistic sensitivity, and scholarly preparedness and tact" (p. 228). Although an unexpected event interrupted the inquiry process, every stage of the research was conducted with integrity and with deliberate practice of *Epoche*. Using the process of *Epoche* consistently helped me maintain an unbiased phenomenological positioning towards the data.

As a sign of respect for the co-researchers who so candidly shared their stories, a short letter explaining the reason for the delay in completing the study was sent to participants who had expressed the desire to receive a summary of the findings at the time of their interviews. They will be sent a summary once this dissertation has been successfully defended.

Implications for Future Research

The evidence presented in the education literature is clear; conducive learning environments based on research about how the brain learns contribute to enhanced cognitive processes, to the development of higher thinking skills and deeper learning (Glick, 2011; Jensen, 2008; Schank, 2011; Sousa, 2011). The literature also suggests that certain levels of stress and anxiety may hinder and even block the brain's ability to learn (Hannon et al., 2010; Sousa, 2011). Co-researchers expressed that under FA conditions, they could think more clearly and were less prone to making mistakes because their cognitive processes were not hindered by the fear of being evaluated. This finding suggests that using FA in clinical nursing courses may enable cognitive processes so current knowledge can be accessed effectively and may foster learning, resulting in

potentially safer nursing practice. Further research on integrating FA into clinical courses is warranted.

While the focus of this inquiry was on the phenomenon of assessment, it provided evidence that the traditional practice of CPA significantly impacts nursing students' learning experience in clinical courses. Ultimately, the findings of this study point to the value of FA in clinical nursing courses and to the potential for enhancing learning by increasing the amount of FA in clinical courses. While SA remains a fundamental component of clinical courses, the findings suggest that increasing the use of FA and refining the assessment process so SA is done at predetermined times that are clearly conveyed to students, may foster learning by providing more opportunities to learn and to develop skills and abilities before getting evaluated for the summative grade. As the amount of published literature criticizing the process of CPA continues to grow, it is evident that the time has come to investigate new ways of assessing student learning in clinical nursing courses.

Statements about the potential of formative feedback were pervasive throughout the co-researchers' accounts. The literature on the benefits of feedback was prevalent; nevertheless, many authors claimed that feedback can be unhelpful when it is too general or vague (Andrade, 2010; Black & Wiliam, 1998; Hattie & Timperley, 2007; Irons, 2008; Pollock, 2012; Tee & Ahmed, 2014). To fulfill the purpose of guiding student learning and enhancing performance, effective feedback should be "precise, specific, and instructional …. delivered using varied and relevant modes …. prompt …. individualized, based on the needs of the student …. [and] given in private" (Oermann, 2015, pp. 243–244). Recognizing the important value of feedback for improving future

performance, Gigante, Dell, and Sharkey (2011) used the acronym STOP to describe effective feedback. For them, effective feedback must be "specific, timely, objective and based on observed behaviors, plan for improvement discussed with learner" (Gigante et al., 2011, p. 205). Gigante et al. maintained that feedback is a critical, necessary, and valuable skill for educators, and Erlauer (2003) pointed to the importance of giving feedback in a planned and purposeful manner. Furthermore, "frequent formative assessment and corrective feedback are powerful tools to promote long-term memory and develop executive functions of reasoning and analysis" (Willis, 2010, p. 56). This inquiry's findings suggest that future research on ways to integrate regular formative feedback into clinical nursing education practices may be warranted.

As a phenomenological study, this inquiry did not intend to confirm findings. However, to situate and enhance their presentation, the findings were correlated with the literature. Interestingly, the later review led to the unanticipated identification of a noteworthy gap in the nursing education literature; that is, a scarcity of research on integrating brain-based pedagogy in clinical practice environments. Literature on the value of using interactive technology for clinical teaching continues to grow, and a wealth of literature on integrating high-fidelity simulation as an innovative approach to nursing curriculum design and delivery is widely available (Bonnel & Smith, 2010; Mastrian, McGonigle, Mahan, & Bixler, 2011; Weatherspoon & Wyatt, 2012). Furthermore, literature on integrating brain-compatible teaching and learning strategies such as concept mapping, and problem-based learning in classroom-based nursing courses is growing (Jacoby, Heugh, Bax, & Branford-White, 2014; Oermann, 2015; Paige & Smith, 2013; Sand-Jecklin, 2007). However, there is little evidence available on

the specific benefits of using teaching and learning strategies guided by educational neuroscience evidence in clinical settings where students practice nursing.

Various modes of assessment such as portfolios, concept maps, simulation scenarios, learning logs, peer assessment, and reflective journals are some of the formative assessment strategies discussed in the literature (Allen & Prater, 2011; Billings & Halstead, 2012; Bonnel & Smith, 2010; Boyle & Charles, 2014; Duers & Brown, 2009; Gaberson et al., 2015; Havnes & McDowell, 2008; Leung, Mok, & Wong, 2008). The literature addresses the use of these strategies in classroom-based courses; however, because of the dearth of literature on the integration of theses strategies in clinical nursing courses, further research is warranted.

As urged by Ferguson and Day (2005) and reiterated by Gaberson et al. (2015) and Benner et al. (2010), "evidence-based nursing education is dependent on a research-based body of knowledge to create the 'best evidence' needed for the judicious application of evidence to individual nursing programs and students situations" (Ferguson & Day, 2005, p. 114). Amongst a significant number of authors, Roberts (2002) alluded to the congruence between experiential pedagogy and brain-compatible educational principles. This inquiry's results suggest that many contextual factors associated with clinical nursing experiences may influence brain functioning and consequently impact the quality of nursing students' learning experience in clinical courses. Because experiential learning is a fundamental aspect of clinical nursing education and because little evidence was found on the value of using cognitive science research to guide pedagogical decisions in clinical courses, future research of the impact of integrating brain-based pedagogy within clinical nursing education is warranted.

Personal and Professional Ramifications

Through a transcendental phenomenological inquiry, I sought to uncover and describe the experience of assessment in clinical courses from the perspective of third year students enrolled in a baccalaureate degree in nursing. Through my research, the traditional process of CPA was brought to the forefront as the practice of embedding FA in clinical courses was studied from the students' perspective. Conducting this research validated my decision to enroll in the *Cognition and Learning* stream of the Joint PhD in Educational Studies. Instead of satisfying my curiosity about how I could use assessment to facilitate learning in clinical courses, this inquiry sparked more questions about the integration of cognitive processes-based pedagogy in clinical nursing education. Consequently, I plan to devote future work to this issue.

Knowledge translation is important for any research, but especially when it focuses on issues that are poorly discussed in the literature. Because this research addressed a significant gap in the nursing literature and because it led to the identification of a further gap, it has the potential to inform pressing curricular issues facing nursing education at this time. Implications for the teaching–learning process derived from this study will be shared with the nursing community at the national and international level as well as with other professional programs where students are required to complete clinical courses in related communities of practice.

Conclusion

As the demands of the health care system become more complex, new graduates of nursing programs are expected to have a specialized body of knowledge combined with the ability to adapt and function in unpredictable situations (Billings & Halstead,

2012; McIntyre & McDonald, 2014; Villeneuve & MacDonald, 2006). "Today's nursing students must learn more, do more, be more … they must master a tremendous amount of information and learn a wide variety of skills so they can pass the licensure exam and become highly skilled nurses" (Catalano, 2012, p. ix). Hence, it is imperative that the traditional model of clinical nursing education be examined because "much of the educational practicum is all too often carried out '*the way we've always done it*,' without adequate consideration being given to what works and why, or why something else might work better" (DeYoung, 2009, p. 16). The literature on using cognitive science in classroom-based nursing courses is evolving; however, the literature on integrating brain-based research in clinical nursing courses remains scarce.

Although giving voice to the nursing students who volunteered to be co-researchers contributed to elucidate their experience with assessment, generalization of the findings is incongruent with the phenomenological underpinnings of this inquiry. Uncovering the essence of the phenomenon extended our understanding of the phenomenon of assessment by providing a snapshot of what is was like for participants to be assessed in clinical courses where FA was formally embedded and how they lived that experience. The co-researchers who shared their stories played a significant role in identifying strategies that enhanced their unique experience within clinical courses and, consequently, their learning. Readers are urged to judge the transferability of these findings in light of their individual contexts and experience.

It is clearly stated in the literature that reflective practice and regular formative feedback associated with FA enhance the skills of self-regulation, leading to lifelong learning (Boyle & Charles, 2014; Brookhart, 2009; Earl, 2013; Wiliam, 2011a, 2011b).

Recognizing that self-regulation is learnable, Andrade (2010) developed a model identifying FA and self-assessment as two features of self-regulation. She explained that through FA and reflective practice, such as self-assessment, students learn to appraise, adapt, and adjust their own learning, and, consequently, develop skills of self-regulation. Referring to self-regulation, Earl (2013) explained, "it occurs when students personally monitor what they are learning and use the feedback from this monitoring to make adjustments, adaptations, and even major changes in what they understand" (p. 28). Tomorrow's nurse will need skills of self-regulation in order to adapt to the ever-changing nature of health care environments (Benner et al., 2010; Catalano, 2012; McIntyre & McDonald, 2014; Ross-Kerr & Wood, 2011; Villeneuve & MacDonald, 2006); therefore, "professional education must go beyond current knowledge and skills to prepare for practice in the future" (Gaberson et al., 2015, p. 9). Oermann and Gaberson (2014) identified the "the ability to apply concepts and theories to new situations, problem solving, critical thinking and clinical judgment" (p. 125) as cognitive skills essential for nursing practice in the future. The available literature conclusions are clear; FA fosters learning and, if used consistently, it may contribute to heightened skills of self-regulation, deeper learning, and the ability to function in dynamic environments.

Student engagement in lifelong learning, critical thinking, and skills of adaptability are essential for the nursing graduate of the 21st century (Benner et al., 2010; Catalano, 2012; Del Prato, 2010; McIntyre & McDonald, 2014; Ross-Kerr & Wood, 2011; Villeneuve & MacDonald, 2006). The fact that nursing education must prepare nurses to practice now and in the future rather than in the past suggests that traditional ways of teaching nursing may be obsolete. As evidenced in this dissertation, repeated

calls for educational reform in nursing education have pervaded the nursing literature for years. As suggested by Hagstrom (2006), "the use of summative and formative learning and assessment practices by today's educators impacts the professional selves of tomorrow" (p. 33). Dramatic decisions must be made to innovate the field of nursing education in order to prepare nurses for the present and for the future.

The findings of this inquiry have shown that integrating FA into clinical courses enhances the learning environment, shifts the focus from evaluation to assessment, and puts the student at the center of the teaching and learning process. By bringing to light the phenomenon of assessment, I have, hopefully, added to the knowledge underpinning nursing education strategies and sparked reflection on the advantage of using cognitive theory to support a more pervasive integration of FA to clinical nursing education.

> If all teachers accept the need to improve practice, not because they are not good enough, but because they can be even better, and focus on the things that make the biggest difference in their students, according to the research, we "will" be able to prepare our students to thrive in the impossibly complex, unpredictable world of the 21st century. (Wiliam, 2011a, p. 162)

Relating the findings of this inquiry with the education literature provided evidence that a more deliberate integration of FA into clinical nursing education has the potential to enhance the learning potential of clinical courses. It addresses a long-standing problem where most students view clinical experiences as stressful situations where testing takes precedence over opportunities for learning (Del Prato, 2010; McCutchan, 2010; Reilly & Oermann, 1999; While, 1991; Wiles & Bishop, 2001). Nursing students need time to learn; however, this is not always provided in the traditional model of clinical education.

Evaluating nursing students as they perform blurs the line "between learning time and evaluation time" (DeBrew & Lewallen, 2014, p. 631). Koh (2008) claimed that "students' perceptions of assessment depend less on how it is actually designed, but more on how it is presented" (p. 227). This implies that the way assessment is conducted, the specificity of the information it provides students, and a clear understanding of the intention of specific assessments are essential. Recognizing the importance of focusing assessments on learning rather than performance may contribute to shift clinical environments from evaluative contexts to learning milieus and, consequently, enhance students' potential for learning in clinical courses.

I suggest a paradigm shift from traditional CPA practices to a more pervasive integration of FA in clinical courses so that students have time to learn before being graded. Moving from an evaluation philosophy to a culture of assessment would shift the focus from the teaching process to a learning process where assessment and feedback are at the center of student learning (Shepard, 2000).

Furthermore, this inquiry and the literature consulted provided evidence that using cognitive theory to inform and reform clinical nursing education is a timely option that may answer the repeated and urgent calls to move nursing education into the 21st century. In their systematic review of clinical assessment in nursing education, Wu, Enskar, Lee, and Wang (2015) identified the need to develop new and holistic models of clinical assessment that nurture the learner and facilitate the development of competent nursing practice. Developing clinical models guided by a culture of assessment and using evidence-informed educational neuroscience to inform clinical nursing education may bring the culture shift that the nursing profession has so overtly longed for.

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Appendix A

Modification of the van Kaam Method of Analysis of Phenomenological Data

1. ***Listing and Preliminary Grouping***
   List every expression relevant to the experience (Horizonalization)
2. ***Reduction and Elimination*****:** To determine the invariant constituents**:**
   Test each expression for two requirements
   a. Does it contain a moment of the experience that is a necessary and sufficient constituent for understanding it?
   b. Is it possible to abstract and label it? If so, it is a horizon or the experience. Expressions not meeting the above requirements are eliminated. Overlapping, repetitive, and vague expressions are also eliminated or presented in more exact descriptive terms. The horizons that remain are the invariant constituents of the experience.
3. **Clustering and Thematizing the Invariant Constituents:**
   Cluster the invariant constituents of the experience that are related into a thematic label. The clustered and labeled constituents are the core themes of the experience.
4. **Final Identification of the Invariant Constituents and Themes by Application: Validation**
   Check the invariant constituents and their accompanying theme against the complete record of the research participants. (1) Are they expressed explicitly in the complete transcription? (2) Are they compatible if not explicitly expressed? (3) If they are not explicit or compatible, they are not relevant to the co-researcher's experience should be deleted.
5. **Using the relevant, validated invariant constituents and themes, construct for each co-researcher and *Individual Textural Description* of the experience.**
   Include verbatim examples from the transcribed interview.
6. **Construct for each co-researcher and *Individual Structural Description* of the experience based on the Individual Textural Description and Imaginative Variation.**
7. **Construct *for each research participant* a *Textural-Structural Description* of the meanings and essences of the experience, incorporating the invariant constituents and themes.**

   From the Individual Textural-Structural Descriptions, develop a Composite Description of the meanings and essences of the experience, representing the group as a whole.

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Appendix B

Interview Guide

Uncovering the Lived Experience of Nursing Students With Formative Assessment Formally Embedded in Clinical Courses

Please note: In accordance with the transcendental phenomenological approach to human science inquiry, a brief conversation aimed at making students comfortable and to foster trust will take place before the interview begins. Upon starting the tape recorder, I will thank participants for their time and reiterate the confidential nature of their responses. Although the focus of the research will be maintained, each individual interview will be guided by participants' descriptions.

1. Please give an example of a situation when you were assessed formatively in a clinical course.
2. What aspects of this experience stand out for you?
3. How did this experience affect you?
4. What were you feelings during this experience?
5. What thoughts stood out for you?
6. What physical changes were you aware of at that time?
7. What else can you share about this experience that is significant?
8. How do you see the purpose of clinical courses in your nursing program?
9. When you mention …X… what do you mean?
10. Is there anything else you would like me to know regarding FA in clinical courses?

(Thank participants for their time and participation. Reiterate the confidential nature of their responses.)

Appendix C

Participant Dossier

Uncovering the Lived Experience of Nursing Students With Formative Assessment Formally Embedded in Clinical Courses

Name: **Pseudonym:**

Address:

Phone #: E-mail:

Interview

Date: Length:

Interview tape to be destroyed YES
NO, given to participant

Miscellaneous Information

Thank you letter sent Date:

Final report requested YES NO

Appendix D

Information Processing Model

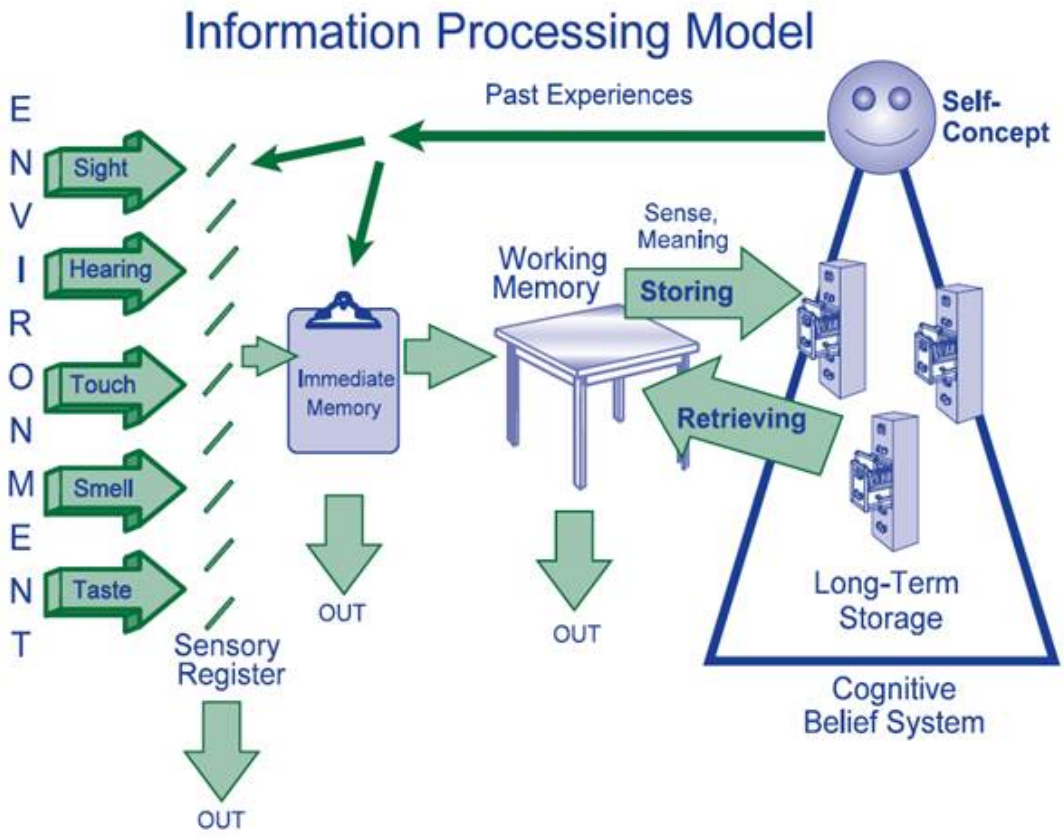

Figure 2.1 The Information Processing Model represents a simplified explanation of how the brain deals with information from the environment. Information from the senses passes through the sensory register to immediate memory and then on to working memory for conscious processing. If the learner attaches sense and meaning to the learning, it is likely to be stored. The self-concept often determines how much attention the learner will give to new information.

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